



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Joint Fiscal Committee Members  
From: Nathan Lavery, Fiscal Analyst  
Date: September 14, 2012  
Subject: Grant Request

Enclosed please find four (4) items that the Joint Fiscal Office has received from the administration.

**JFO #2578** – Request to establish **one limited service position** in the Department of Children and Families. This position will lead the rollout of a new commodity food ordering system that will allow recipients to better manage school food programs, menus, and budgets.  
[JFO received 9/11/12]

**JFO #2579** – In-kind donation of \$25,000 worth of services from State Smart Transportation Initiative (SSTI) to the Vermont Agency of Transportation. SSTI will support the preparation of a comprehensive transportation funding study required under Section 40 of Act 153. The amount of this donation is an estimate of the value of SSTI's work. No funding will be provided directly to, or flow through, the State of Vermont.  
[JFO received 9/14/12]

**JFO #2580** – \$77,800 worth of land donated by Sarah Scharfenaker and Tom Koehne to the Vermont Department of Fish & Wildlife. This amount represents the value of 37 acres of land to be added to the Calendar Brook Wildlife Management Area.  
[JFO received 9/14/12]

**JFO #2581** – Request to establish **twenty-three (23) limited service positions** in the Department of Vermont Health Access. These positions will work to design and implement the Health Services Enterprise System, with the intention of modernizing and replacing existing systems with an interoperable, digital, real-time health IT network.  
[JFO received 8/20/12]

Please review the enclosed materials and notify the Joint Fiscal Office (Nathan Lavery at (802) 828-1488; [nlavery@leg.state.vt.us](mailto:nlavery@leg.state.vt.us)) if you have questions or would like an item held for Joint Fiscal Committee review. Unless we hear from you to the contrary by September 28 we will assume that you agree to consider as final the Governor's acceptance of these requests.

**STATE OF VERMONT  
Joint Fiscal Committee Review  
Limited Service - Grant Funded  
Position Request Form**

JFO 2581

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report must be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS - DVHA Date: 8/17/12

Name and Phone (of the person completing this request): Jill Gould 802-879-8240

Request is for:

- Positions funded and attached to a new grant.
- Positions funded and attached to an existing grant approved by JFO # N/A - Medicaid

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

Department of Health and Human Services - Centers for Medicare and Medicaid Services (CMS) 0 Implementation Advanced Planning Document (IAPD) - Vermont Health Enterprise. Award letter attached.

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

<u>Title* of Position(s) Requested</u>	<u># of Positions</u>	<u>Division/Program</u>	<u>Grant Funding Period/Anticipated End Date</u>
List Attached <i>highlighted in yellow</i>	23	Various	9/30/15

\*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

The Vermont Health Enterprise will modernize and replace our Eligibility and Enrollment (E&E) and Medicaid Management Information System (MMIS) while taking advantage of a short-term window of enhanced funding that will build an IT platform that will eventually benefit all of the Human Services Programs. It is imperative that we have these positions to help design, develop and implement the system(s) within the aggressive deadlines.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b)).

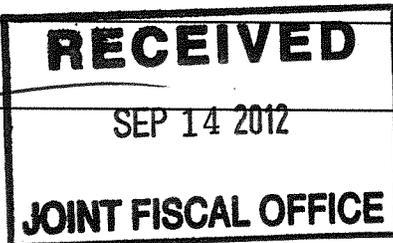
Signature of Agency or Department Head [Signature] Date 8-17-12

Approved/Denied by Department of Human Resources [Signature] Date 8/23/12

Approved/Denied by Finance and Management [Signature] Date 9/11/12

Approved/Denied by Secretary of Administration [Signature] Date 09/11/12

Comments:



AUG 24 2012

State of Vermont  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston VT 05495-2807  
dvha.vermont.gov

[Phone] 802-879-5900  
[Fax] 802-879-5651

Agency of Human Services

TO: Emily Byrne, Budget Analyst  
Department of Finance & Management  
Molly Ordway-Paulger, Director of Classification, Compensation & HRIS  
Department of Personnel

THRU: Doug Racine, Secretary   
Agency of Human Services

FROM: Mark Larson, Commissioner  
Department of Vermont Health Access 

DATE: August 17, 2012

SUBJECT: JFC – Limited Service Position Request related to Health Enterprise Services IAPD  
(Jumbo IAPD)

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Please accept this request to create twenty-three (23) Limited Service Positions related to the Vermont Health Services Enterprise Advanced Planning Document which was approved by CMS May 4, 2012.

These positions are needed for the Design, Development and Implementation of the Health Services Enterprise Systems including the Eligibility and Enrollment System (E&E), Medicaid Management Information Services (MMIS), and the State Medicaid Health Plan (SMHP-HIT).

DVHA has received approved federal funding to support the Health Services Enterprise Project which combines various enhanced funding opportunities into one application “jumbo” IAPD and one award letter so we may more easily leverage core component IT systems that benefit multiple federal programs. This “jumbo” IAPD has increased funding for these projects as well as combined and supersedes four (4) already approved individual IAPD (VIEWS, MMIS, Infrastructure and SHMP) funding and positions. DVHA and CMS have agreed to eventually fold in the funding for the Health Benefits Exchange (HBE) into this award for cost allocation purposes. Although the HBE funding will be awarded through individual grants, that final approved funding will be represented in this “jumbo” documentation for approved cost allocation and tracking purposes. Currently the “Jumbo” IAPD and Level 1 Exchange grant have approved funding for sixty-nine (69) positions; these are listed in the attached document.

In addition, we have applied for and are waiting for the Notice of Grant Award for the Health Benefit Exchange Level 2 funding. When received, we will submit an AA-1 and request for an additional twenty-one (21) limited service positions. The Level 2 Grant Award will support sixty-six (66) positions through implementation. Twenty-nine (29) positions have already been created through the Planning grant, Level 1 or statutory approval, five positions are partially funded base positions, and eleven (11) other positions overlap with the jumbo IAPD E&E project, and have been requested in this submission.

All required and relevant grant documentation has been attached. If you have any questions or are in need of further information, please feel free to give me a call. Thank you for your attention in this matter.

AUG 24 2012





Job Type	Count	Created	New Request	Position Number	FTE	Position Title	Department	Original Program Funding	Funding Source	Comments
IT	1	1	0	720148	1	Project Manager	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 1
IT	1	1	0	720154	1	Business Analyst	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 2
IT	1	1	0	720151	1	SOA QA Integrator - Senior Sys Dev	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 3
IT	1	1	0	720153	1	SOA Developer 1	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 4
IT	1	1	0	720152	1	SOA Developer 2	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 5
IT	1	1	0	720155	1	Database Administrator	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 6
IT	1	1	0	720149	1	Admin. Asst. for AHS IT	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 7
IT	1	1	0	720150	1	Infrastructure / Architecture Security Specialist	AHS IT	HIX	HIX Level 1 Grant	Approved JFO 2550 - 8
Program	1	1	0	730187	1	Financial Admin I	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 9
Program	1	1	0	730188	1	Financial Specialist II	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 10
Program	1	1	0	730189	1	Executive Office Manager	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 11
Program	1	1	0	010015	1	Admin. Asst. for AoA	AoA	HIX	HIX Level 1 Grant	Approved JFO 2536
Program	1	1	0	730179	1	Health Care Policy Analyst	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 12
Program	1	1	0	730180	1	Health Access Policy & Planning Chief	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 13
Program	1	1	0	010014	1	Attorney/Policy Analyst	AoA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 14
Program	1	1	0	730182	1	Change Management Director	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 15
Program	1	1	0	730186	1	Contract & Grants Administrator	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 16
Program	1	1	0	737010	1	Deputy Commissioner	DVHA	HIX	HIX Level 1 Grant	Approved by Statute
Program	1	1	0	730181	1	Exchange Project Director	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 17
Program	1	1	0	730190	1	Outreach Program Manager	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 18
Program	1	1	0	730183	1	Exchange Project Director	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 19
Program	1	1	0	730184	1	Exchange Project Director	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 20
Program	1	1	0	730185	1	Exchange Project Director	DVHA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 21
Program	1	1	0	290130	1	Project Coordinator	BISHCA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 22
Program	1	1	0	290129	1	Director, QHP Certification	BISHCA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 23
Program	1	1	0	290131	1	Data Analyst	BISHCA	HIX	HIX Level 1 Grant	Approved JFO 2550 - 24
Program	1	1	0	270011	1	Data Analyst	GMCB	HIX	HIX Level 1 Grant	Approved JFO 2550 - 25
Program	1	1	0	751100	1	Business Analyst	DCF	HIX	HIX Level 1 Grant	Approved JFO 2550 - 26
Program	1	1	0	751101	1	Business Analyst	DCF	HIX	HIX Level 1 Grant	Approved JFO 2550 - 27
IT	1	1	0	720157	1	Data Base Administrator - Health Enterprise	AHS IT	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 1
IT	1	1	0	720158	1	Enterprise Business Analyst - Provider Directory	AHS IT	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 2
Program	1	1	0	730213	1	Health Reform Enterprise Director	DVHA	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 3
Program	1	1	0	730209	1	Business Analyst	DVHA	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 4
Program	1	1	0	730211	1	Health Reform Portfolio Director	DVHA	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 5
Program	1	1	0	730212	1	Health Reform Portfolio Director	DVHA	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 6
Program	1	1	0	730214	1	Health Reform Portfolio Privacy Policy Specialist	DVHA	MMIS/Portfolio	MMIS P&P-U	Approved JFO #2562 - 7
Program	1	1	0	730177	1	EHRIP Medicaid Operations Administrator	DVHA	EHRIP	SMHP IAPD	Approved JFO 2543 - 1
Program	1	1	0	730175	1	EHRIP Medicaid Operations Administrator	DVHA	EHRIP	SMHP IAPD	Approved JFO 2543 - 2
Program	1	1	0	730174	1	EHRIP Program Operations Auditor	DVHA	EHRIP	SMHP IAPD	Approved JFO 2543 - 3
Program	1	1	0	730178	1	EHRIP Administrative Support Coord.	DVHA	EHRIP	SMHP IAPD	Approved JFO 2543 - 4
Program	1	0	0	NONE	0	Senior Business Analyst	DVHA	EHRIP	Combined IAPD	Not requested at this time
IT	1	1	0	740835	1	Public Health Informatics Specialist	VDH	IZ Registry	SMHP IAPD	Existing Position
IT	1	1	0	740063	1	Public Health Analyst III	VDH	IZ Registry	Combined IAPD	New JFO Request
IT	1	1	0	740512	0.25	Senior Systems Developer	VDH	IZ Registry	SMHP IAPD	Existing Position
Program	1	1	0	NONE	0	Senior Business Analyst	VDH	IZ Registry	SMHP IAPD	Existing Position
Program	1	1	0	NONE	0	Senior Business Analyst	DVHA	Provider Directory	Combined IAPD	Not requested at this time
Program	1	1	0	730171	1	Medicaid Operations - Provider Directory	DVHA	Provider Directory	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Interactive Marketing and Web Developer	DVHA	EHRIP	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Fiscal Analyst	DVHA	EHRIP	SMHP IAPD	Approved JFO 2543 - 5
Program	1	1	0	730176	1	Medicaid Fiscal Analyst	DVHA	E&E	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request
Program	1	1	0	730176	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request

Job Type	Count	Created	New Request	Position Number	Position Title	Department	Original Program		Funding Source	Comments
							FTE	Funding		
Program	1	0	1	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Eligibility Specialist	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Benefits Program Assistant Administrator	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Benefits Program Assistant Administrator	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Economic Services Supervisor	DCF	E&E	Combined IAPD	New JFO Request	
Program	1	0	1	1	Health Care Program Specialist	DCF	E&E	Combined IAPD	New JFO Request	
IT	1	0	1	1	Enterprise Business Analyst	AHS IT	E&E	Combined IAPD	New JFO Request	
IT	1	0	1	1	Enterprise Business Analyst	AHS IT	E&E	Combined IAPD	New JFO Request	
IT	1	0	1	1	Enterprise Business Analyst	AHS IT	E&E	Combined IAPD	New JFO Request	
IT	1	0	1	1	Enterprise Business Analyst	AHS IT	Enterprise	Combined IAPD	New JFO Request	
IT	1	0	1	1	Senior Systems Developer	AHS IT	Enterprise	Combined IAPD	New JFO Request	
<b>TOTAL</b>	<b>69.00</b>	<b>44.00</b>	<b>23.00</b>	<b>Total</b>						<b>66.25</b>

*all RFRs received for new positions - yellow highlighted*

*HOP*

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
Consortium for Medicaid and Children's  
Health Operations  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601



May 4, 2012

Mark Larson  
Commissioner  
State of Vermont, Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

Dear Mr. Larson:

Thank you for the submission of your Implementation Advance Planning Document (IAPD) entitled Vermont Health Enterprise, initially submitted to the Centers for Medicare & Medicaid Services (CMS) on March 13, 2012 with a revised submission on April 04, 2012. The IAPD provides a comprehensive plan to support Health Information Technology (HIT) and Health Reform Information Technology (IT), referred to as the portfolio. The portfolio includes underlying common IT shared services and tools to support the Health Insurance Exchange (HIX), the Eligibility and Enrollment (E&E) system, Financial Management systems, public health information, health data, health surveillance technologies and the full Medicaid Management Information System (MMIS) or Medicaid Enterprise Solution (MES) architecture. CMS has completed its review of your IAPD and approves your project, as follows:

**Health Information Technology (HIT)**

The IAPD was submitted to CMS for review and approval to proceed with certain activities authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub L. 111-5, and our regulations at 42 CFR Part 495, Subpart D. The Social Security Act, as amended under Section 4201 of the Recovery Act, as well as our final regulation, allows the payment of incentives to eligible professionals and eligible hospitals for the adoption and meaningful use of certified electronic health record (EHR) technology.

CMS approves Vermont's IAPD effective on the date of this letter. Our approval of the State's IAPD is subject to provisions in regulations at 42 CFR Part 495, Subpart D.

CMS is approving funding for health information exchange activities described in Vermont's IAPD in an amount not to exceed \$7,159,688 (Federal share \$6,443,720). This funding breaks out as follows: \$1,618,885 (Federal share \$1,456,996) for Federal Fiscal Year (FFY) 2012, and \$5,540,804 (Federal share \$4,986,723) for FFY 2013. Please note that these amounts reflect a

reduction due to funding provided by private payers in the amount of \$4,507,358 as well as a grant from the Office of the National Coordinator (ONC) in the amount of \$2,600,000. Also note that CMS has determined that the telemedicine development and e-prescribing items are not appropriate for HIT funding at this time.

Vermont is also revising the funding amounts from its previously approved IAPD, approved by CMS on September 23, 2011. CMS is approving \$2,188,599 (Federal share \$1,969,739) for FFY 2012, and \$2,080,581 (Federal share \$1,872,523) for FFY 2013.

In total, CMS is approving funding for HIT activities described in Vermont's IAPD in an amount not to exceed \$11,428,869 (Federal share \$10,285,982). The total approved funding for HIT activities in this IAPD breaks out as follows: \$3,807,484 (Federal share \$3,426,735) for FFY 2012, and \$7,621,385 (Federal share \$6,859,247) for FFY 2013. Approval of funding for all HIT activities will expire on September 30, 2013. Please refer to Enclosure A for a breakout by expense of approved HIT implementation funds.

This approval letter replaces the September 23, 2011 approval letter and represents all approved funding for the State's Medicaid Electronic Health Record Incentive Program going forward.

As described in our regulations at 42 CFR Part 495, Subpart D, Requests for Proposals (RFPs) or contracts that the State may utilize to complete incentive program activities must be approved by CMS prior to release of the RFP or prior to execution of the contract. Also, the State must fund its share consistent with the requirements of section 1903(w) of the Social Security Act, implementing regulations, CMS guidance and other applicable laws, rules, and regulations.

Annual HIE-related benchmarks and performance measures included in Enclosure B must be addressed each year. Also, please refer to Enclosure C for additional information about the State's responsibilities concerning activities described in the IAPD.

If there are any questions concerning this information, please contact Jessica Kahn at (410) 786-9361, or via email at [Jessica.Kahn@cms.hhs.gov](mailto:Jessica.Kahn@cms.hhs.gov).

#### **Eligibility & Enrollment System (E&E)**

CMS approves your IAPD for the design, development and implementation (DDI) for an Eligibility and Enrollment system effective on the date of this approval letter for Federal fiscal year 2012 through FFY 2014 (September 30, 2015) for a total project cost \$21,470,560. This total project cost represents the Medicaid and CHIP program share of your core components which is the sum of the allocated costs for the shared functionality of the HIX and the costs of the new replacement E&E system. CMS is approving total Medicaid Federal Financial Participation (FFP) title XIX development costs of \$19,323,504 at an enhanced match rate (refer to the State Medicaid Manual Part 11 for specific FFP rates for the variety of activities supporting proper matching rates; specifically noting that COT's license(s) are considered at a 75 percent match and training at a 50 percent match) which results in a State share amount of \$2,147,056.

To provide guidance to you on State share, States are required to fund the non-Federal share consistent with Federal rules and regulations at section 1903(w)(6)(A) and 42 CFR 433.51. CMS may review the non-Federal share funding sources on an individual basis using information provided by the State and gathered by CMS staff. Please be mindful that all sources of the non-Federal share and any fees, taxes, or donations must meet the requirements of section 1903(w) of the Social Security Act, implementing regulations, CMS guidance, and other applicable laws, rules, and regulations.

In support of approving Vermont's overall project to develop a replacement E&E system comprised of core components and shared services including Master Data Management (MDM), Identity Management, Enterprise Service Bus (ESB), Workflow solution, Rules Engine, Enterprise Master Persons Index (EMPI), Portal, Provider Directory, Imaging / Electronic Records Management expansion, Data Warehouse, an automated Call Center, related staffing costs, and additional E&E development, CMS approves for FFY 2012 a budget amount of \$2,615,430 for DDI project costs. Specifically, CMS is approving Medicaid FFP title XIX development costs of \$2,353,887 for FFY 2012. Please see the following table for the 2012 funding approval amounts with corresponding FFP rates.

Federal / State Program FFY 2012	Program Share of Cost	Amount (\$)	FFP Rate*	Federal Share (\$)	State Share (\$)
Phase I DDI Title XIX		\$2,615,430	90%	\$2,353,887	\$261,543
Phase I DDI Title XXI**		0		0	0
Phase I DDI		\$2,615,430		\$2,353,887	\$261,543
<b>TOTAL PROJECT COSTS, FFY 2012</b>		\$2,615,430		\$2,353,887	\$261,543

\*\*The State of Vermont CHIP population is minimal (approximately .06% of total population) and per CMS EHR guidance, CHIP allocation is included in the Medicaid allocation (page 47 of IAPD).

The CMS approves the State of Vermont's IAPD in accordance with Federal regulations at 42 CFR part 433, subpart C regarding Mechanized Claims Processing and Information Retrieval Systems, and 45 CFR part 95, subpart F regarding Automatic Data Processing Equipment and Services - Conditions for FFP. We are approving Vermont's IAPD for the development of an integrated eligibility system at the applicable enhanced FFP match rate as the State has provided assurances that it will comply with the seven standards and conditions specified in 42 CFR part 433, subpart C, as modified by the final rule, "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," published in the *Federal Register* on April 19, 2011. In addition, we remind you that we will be monitoring the progress of Vermont's project using a Systems Development Life Cycle (SDLC) model that parallels the Exchange Life Cycle Gate Review process that the Center for Consumer Information and Insurance Oversight (CCIIO) is utilizing. This approach supports the high degree of interaction that will be required between Medicaid, the Children's Health Insurance Program (CHIP), and the Exchanges and the use of a shared eligibility service among the programs.

The information that you submit to CCIIO for the purposes of any Exchange grant application may also be used to satisfy the necessary documentation related to this IAPD document. We will be closely collaborating with our Federal partners in CCIIO on the oversight of your project. In addition and as part of the monitoring and review process, please provide:

- Monthly status reports, to report on the status of your project including updates to your project management plan and risk register in accordance with your risk plan.
- IT artifacts, made available in the Collaborative Application Lifecycle Management tool (CALT) as required through the SDLC gate review process that supports your project.
- Independent Verification and Validation (IV&V) reports. Since this IAPD includes estimated costs for an IV&V vendor, we request to review IV&V reports throughout the SDLC gate review process.
- Alternatives Analysis and Cost Benefit Analysis which supports your solution decisions during your Initiation and Planning phase of your gate review process.
- A more detailed Project Management Plan including key milestones demonstrating your iterative approach to project development including your test period. In addition, when does Vermont plan to complete their MITA State Self Assessment and Roadmap and share that information using CALT? Also, within Section 8 of your IAPD entitled Proposed Activity and Milestone Schedule, you provide a high level schedule of your VIEWS development. From this diagram, it is hard to determine Vermont's planned test period and if adequate time is built into the plan to ensure complete end to end testing and interface testing to support your implementation plan.
- As stated in your IAPD, Vermont is planning an infrastructure to support other non-Medicaid IT projects such as the health care portal, the Data Warehouse solution, and potentially some other facets of core components (see pages 17 through 22 of the IAPD). However, it does not appear that Vermont has elected to take advantage of the opportunity to invoke the OMB A-87 Cost Allocation Exception. We request that you review the latest Tri-Agency letter to States dated January 23, 2012 to confirm your position on the exception. In addition, we request that you include all other applicable human service programs, both from a business as well as technical standpoint, in your design and development of your total project that will ultimately support these programs.

At your request, CMS' prior approval of Vermont's Agency of Human Services and Office of Vermont Health Access IAPD to replace the existing eligibility system with the Vermont Integrated Eligibility Workflow System (VIEWS) dated April 15, 2009 for total project cost of \$34,664,034 is being closed out in support of this new IAPD documenting the change in scope, schedule, and cost allocation methodology. Total expenditures under this previous IAPD were \$127,416.96 and represent planning implementation efforts.

#### **Medicaid Enterprise System (MES)**

The submitted IAPD requests additional FFP of \$100,912,810 to incrementally replace the legacy Medicaid Management Information System (MMIS) with the Vermont Medicaid Enterprise Solution (MES). The legacy MMIS will be transformed over time by replacing components of the legacy system with components that comport with the seven standards and conditions. The cost allocated Total Computable for the MES project is \$112,180,900. State costs are \$11,218,090.

CMS approves the submitted IAPD in accordance with the provisions of 45 CFR 95 Subpart F and Part 11 of the State Medicaid Manual (SMM). This approval authorizes the Department to claim FFP as follows:

- 90 percent FFP in an amount not to exceed \$4,500,000 for State in-house personnel costs
- 90 percent FFP in an amount not to exceed \$19,444,000 for Change Management State in-house personnel costs
- 90 percent FFP in an amount not to exceed \$2,241,810 DDI costs for State in-house personnel costs
- 90 percent FFP in an amount not to exceed \$64,980,000 for DDI costs
- 90 percent FFP in an amount not to exceed \$3,249,000 for IV&V costs
- 90 percent FFP in an amount not to exceed \$6,498,000 for Quality Assurance vendor costs.

Any change in the approved IAPD scope of work, duration or cost requires CMS prior approval of an IAPD amendment in accordance with the provisions of SMM Section 11238 and 45 CFR 95 Subpart F. Should the project deviate from the CMS approved IAPD, FFP for the Vermont MMIS re-procurement project may be suspended or disallowed as provided for in Federal regulations at CFR 95.611(c) (3) and 95.612. In addition, continued Federal funding of the Vermont MES project is contingent upon the following:

1. The Department's ability to demonstrate progress in meeting project milestone commitments as noted in the E&E section and specific to MES funding; and
2. The Department's timely submission of monthly status reports for the MES portion of the project. The monthly status reports should be submitted to this office by the last day of each calendar month beginning with May 2012. Monthly status reports are to be signed by you and include, at a minimum, the following information.
  - **Major Project Accomplishments**  
A description of major project accomplishments since the last report;
  - **Project Status**  
The department's assessment of the current project status as compared to the approved IAPD project schedule including specific reference to all project milestones start and end dates;
  - **Project Problems**  
A description of problems that have or will have an impact on the project schedule or content;
  - **Corrective Action**  
A plan of action to correct any problems identified above;
  - **Funding Summary**  
A cumulative summary of project costs claimed for FFP by rate of FFP.

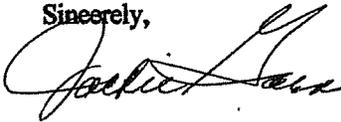
Upon successful implementation of the Vermont MES project, please provide CMS with written notification that includes the following:

1. The date the project was completed and officially accepted by the Department;
2. The final cost to complete the Vermont MES project; and
3. Assurances/documentation that the project, as completed, meets the objectives and performs the functions described in the approved IAPD.

If you have any questions or concerns regarding the MES and E&E sections of this approval, please feel free to contact Ellen Ambrosini at (410)786-6918, [Ellen.Ambrosini@CMS.hhs.gov](mailto:Ellen.Ambrosini@CMS.hhs.gov), or David Guiney at (617)565-1298, [David.Guiney@CMS.hhs.gov](mailto:David.Guiney@CMS.hhs.gov).

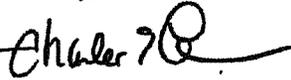
CMS appreciates and supports Vermont's vision to develop a health enterprise, commonly known as Vermont's Health Enterprise Portfolio, which is interoperable, digital, real-time, and a learning health network for its citizens.

Sincerely,



Jackie Garner  
Consortium Administrator

Sincerely,



Charles Lehman  
Director, Division of State Systems

Sincerely,



Richard McGreal  
ARA, Boston

## Enclosure A

**Medicaid EHR Incentive Program Expenses and Approved HIT Funds Through FFY 2013**

<b>HIE FFY 2012</b>	<b>\$1,456,996</b>	<b>\$161,888</b>	<b>\$1,618,885</b>
<b>HIE FFY 2013</b>	<b>\$4,986,723</b>	<b>\$554,080</b>	<b>\$5,540,804</b>
<b>TOTAL FOR HIE</b>	<b>\$6,443,720</b>	<b>\$715,968</b>	<b>\$7,159,688</b>

	<b>Federal Share 90%</b>	<b>State Share 10%</b>	<b>Total</b>
<b>Non-HIE Incentive Program Expenditures for FFQ1 2012 (Oct 1, 2011- Dec 31, 2011)</b>	<b>\$902,991</b>	<b>\$100,332</b>	<b>\$1,003,323</b>
<b>Non-HIE Incentive Program Expenditures for FFQ2 2012 (Jan 1, 2012- March 31, 2012)</b>	<b>\$139,055</b>	<b>\$15,451</b>	<b>\$154,505</b>
<b>Non-HIE Incentive Program Expenditures for FFQ3 2012 (April 1, 2012- June 30, 2012)</b>	<b>\$575,990</b>	<b>\$63,999</b>	<b>\$639,989</b>
<b>Non-HIE Incentive Program Expenditures for FFQ4 2012 (July 1, 2012- September 30, 2012)</b>	<b>\$351,704</b>	<b>\$39,078</b>	<b>\$390,782</b>
<b>TOTAL FOR FFY 2012</b>	<b>\$1,969,739</b>	<b>\$218,860</b>	<b>\$2,188,599</b>
<b>TOTAL FOR FFY 2013</b>	<b>\$1,872,523</b>	<b>\$208,058</b>	<b>\$2,080,581</b>

	<b>Federal Share 90%</b>	<b>State Share 10%</b>	<b>Total</b>
<b>Total FFY 2012</b>	<b>\$3,426,735</b>	<b>\$380,749</b>	<b>\$3,807,484</b>
<b>Total FFY 2013</b>	<b>\$6,859,247</b>	<b>\$762,138</b>	<b>\$7,621,385</b>
<b>TOTAL</b>	<b>\$10,285,982</b>	<b>\$1,142,887</b>	<b>\$11,428,869</b>

**Enclosure B**

**Annual Benchmarks and Performance Measures for HIT Activities**

1. Identify all other payers and how much they have contributed to the Health Information Exchange (HIE) and whether it was direct funding and/or in-kind each year. Have there been successes and challenges with engaging with the other payers? Please provide details.
2. Provide the cumulative number and percentage of total providers successfully connected to the HIE each year overall, the same for total Medicaid providers and of those, broken out by how many are Medicare or Medicaid Eligible Hospitals and Eligible Professionals as known to the State through registration and/or incentive payments. Please provide the cumulative number and percentage of total Medicaid covered lives with data in the HIE each year. Please provide any context for these numbers needed to understand the growth (or lack thereof).
3. Provide a status update for meeting the project schedule and timelines, as outlined in the IAPD.
4. Provide a status update for meeting each of the proposed activities:
  - a. Enable exchange with the immunization registry and electronic exchange with lab results (please use the same data benchmarks as reported to ONC)
  - b. Enhance follow-up support for disease management
  - c. Provide electronic access to medical records for auditing
  - d. Capture quality data for medical home, ACOs, CHIPRA
  - e. Transition from Fee For Service to Pay For Performance- identify opportunities to reward providers who achieve quality outcomes
5. Provide a status update for using the HIE to capture clinical quality measures electronically from EHRs for Medicaid providers participating in the Medicaid EHR Incentive Program.
6. Please provide the prior year's financial statement for the HIE (acknowledging that these may be derived on the State fiscal year, not the Federal fiscal year). Please add additional details as relevant to provide a full picture of financial status.
7. Please identify any changes in HIE leadership (Executive Director, Executive Council, etc) in the prior year.
8. What services is the HIE providing? Please provide data to demonstrate usage of these services. What services will be added in coming fiscal year?
9. Please describe communication and outreach efforts to providers and/or patients and/or payers. Successes and challenges?

# STATE OF VERMONT



Agency of Human Services  
Department of Vermont Health Access

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Vermont Health Enterprise

Implementation Advance Planning Document (IAPD)

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Version 3.4

March, 2012

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# 1 Introduction and Statement of Purpose

The State of Vermont Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) are pleased to submit *VT\_Health\_Enterprise\_APD\_v3.4*, an Implementation Advance Planning Document (IAPD) to the Centers for Medicare and Medicaid Services (CMS). This is a 'first of its kind' IAPD, it is an 'umbrella' APD that provides a framework, structure and method to allow for CMS and the State to document in a single location as complete a summary as possible as to the planning, strategy and budgetary aspects for transforming Vermont's health enterprise into an interoperable, digital, real-time, *learning health network*. This is the result of a tremendous collaborative partnership between Vermont and CMS staff from Center for Consumer Information and Insurance Oversight (CCIIO), CMS Regional Office (RO) and CMS Central Office (CO).

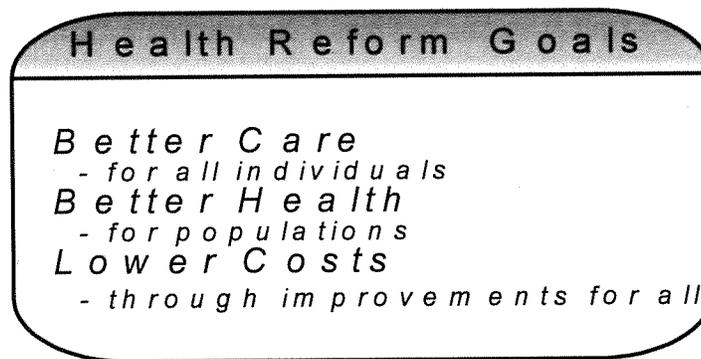
Vermont's Learning Health Network is commonly referred to as Vermont's Health Enterprise Portfolio (Portfolio). The State is in the midst of many initiatives to modernize not only its technology (systems, hardware, software, etc.) but also its business processes. The single State Medicaid Agency, the Agency of Human Services (AHS) is currently involved in a modernization effort to integrate AHS' systems and make them more flexible, integrated and better positioned to support AHS service integration and improve client outcomes. AHS is also seeking to improve and further develop local partnerships, so that human services can be provided in a seamless fashion, addressing the full range of client and community needs leveraging shared services, common technology, and detailed information. CMS' Medicaid Information Technology Architecture (MITA) will help provide the framework to allow the State the ability to meet the goals of increasing electronic commerce and transitioning to a digital enterprise.

The *Vermont Health Information Technology Plan* (VHITP) serves as the operational planning document for the comprehensive collection of Health Information Technology (HIT) and Health Reform Information Technology (IT) systems, the Portfolio. The portfolio includes underlying common IT shared services and tools, the Health Benefit Exchange (HIX), Eligibility & Enrollment (E&E) systems, Financial Management systems, public health information, health data, and health surveillance technologies, and the full Medicaid Management Information System (MMIS) or Medicaid Enterprise Solution (MES) architecture.

The entire Health Services Enterprise Portfolio is being designed and procured, adapted, and/or upgraded in order to meet both current and near-term needs and to ensure that over the coming years, the Enterprise components will transition to support Vermont's envisioned public-private universal health care system. As such, the Portfolio represents not just "building the exchange," procuring "a new MMIS," or expanding HIT, it is a vision for how to wire the "neural network" of Vermont's health system, creating a data utility that provides real time, and close-to-real time, clinical and financial information for the management of the health care system as a *system*.

The procurement of services is vital to this success as it will provide the State with the ability to meet its goals and strategic initiatives leading the way as a leader in development of a health information network with seamless, transparent data liquidity.

This transformation of health reaches immeasurably and requires that all business, information and technical aspects of health work be evaluated and addressed in terms of efficiency, performance and customer service. Staff work closely with not only State associated partners such as BISHCA (Banking Insurance Securities & Health Care Administration) and DII (Department of Innovation and Information) but also with advocates, providers and Federal partners.



The purpose of the Vermont Health Enterprise IAPD is to request CMS approval of Federal Financial Participation (FFP) for expenditures related to this work including but not limited to project planning, design, development and implementation (DDI) efforts, and resource procurement (both human capital and other). This also includes the efforts associated with operational preparation (training and education). Work will be completed by assigned State staff working in close partnership with various contractors. This IAPD will detail on a project level and a budgetary level, how various work activities are related in terms of the Health Services Enterprise Portfolio.

This is a time of unprecedented opportunity for the State and the Federal Government in terms of what can be achieved. We are bringing about Health Reform activities that will reach outward to those that need services and upward to bring about sharing of information. Vermont staff has worked proactively with CMS and HHS leadership to maximize opportunities to strengthen the state / federal partnerships related to implementation of the Affordability Care Act (ACA), to leverage technology being developed by CMS that can be accessed by the states, and to minimize challenges related to the multiple funding streams that characterize all of the portfolio projects.

Vermont's approach to design and procurement of its Health Services Enterprise is tightly aligned with the federal approach to both development and funding of the Health Benefit Exchange, MMIS, and related IT infrastructure components. In April, 2011, CMS published guidance entitled *The Seven*

*Standards & Conditions (S&C) for Enhanced Funding*, which lists requirements that states must meet to leverage the 100%, 90/10, and other federally matched funding streams that support the ACA. The Seven Standards serve as a touchstone for the modular, flexible, interoperable design of the Health Services Enterprise and its emphasis on reusability of portfolio components. In addition to the Seven Standards, a series of three State Medicaid Directors (SMD) letters detail the terms by which states may access HIT funding. Through the Statewide Health Information Exchange (HIE) Coalition, Vermont played a key leadership role in the national discussion about "allowable costs" that qualify for Medicaid support related to HIE.

The modular, integrated design strategy, the "service oriented architecture" (SOA) championed by CMS and embraced by Vermont, results in significant potential efficiencies at the state level, but it also introduces accounting, reporting, and temporal complexities not typical to development of stand-alone "silo" systems. Because of both operational and procurement interdependencies and the complex funds management and cost allocation challenges resulting from multiple, overlapping funding streams, the Health Services portfolio requires close coordination across multiple Departments and Agencies, as well as with CMS.

The value of this work is that it will ultimately promote more effective, efficient and detailed electronic transactions thus facilitating the transition to a robust electronic health care environment. The mandates also ensure the systems maintain compliance with HIPAA standards and maximize the customer's (whether provider, beneficiary or state staff) health care experience. A user of the health care system will have access to the necessary data in a very timely, secure and complete manner based on the privileges assigned to the user. The Vermont Health Enterprise IAPD, this umbrella IAPD, is just one of the first steps towards Vermont and CMS achieving their goals.

In summary, Vermont is submitting this Implementation Advance Planning Document to CMS and is asking CMS to approve the following with an effective date of April 1, 2012:

- 1) approve this APD in terms of bestowing their support and agreeing to partner with Vermont on the work contained within
- 2) approve the closing out of the following APDs as they are now part of this APD:
  - a. SMHP IAPD1
  - b. VIEWS IAPD
  - c. MMIS IAPD1 (SOA Infrastructure IAPD) (includes any update versions also)
  - d. MMIS PAPD-Update1

NOTE: The following APDs still exists as their own separate APDs due to the limited scope and impact of their work:

- a. ICD-10 PAPD
- b. ICD-10 IAPD (being drafted)

- c. 5010
- d. NCCI

3) Approve this APD in terms of the budget totals that are displayed in Section 11 (Prospective Cost Distribution).

## 2 Needs and Objectives

Vermont is recognized as a national leader in the alignment and integration of Health Information Technology (HIT), Health Information Exchange (HIE), and reform of the health care delivery system. The Commonwealth Fund States in Action October / November 2009 newsletter notes that “Minnesota, Wisconsin, and Vermont are among the states involved in cutting-edge HIT initiatives to support evidence-based medicine and improved patient care through transparent reporting of health outcomes and costs.”

For five years, Vermont has been developing an integrated approach to HIT/HIE within a wider context of health reform that specifically includes the state Medicaid program as an integral component. Vermont’s State Medicaid agency, the Department of Vermont Health Access (DVHA), includes the Division of Health Reform (DHR) and is designated by the Governor as the state lead for HIT. DHR, in close collaboration with AHS IT and the DII, plays the role of chief planner, facilitator, and coordinator of implementation for the integrated approach to health IT operational and evaluative systems along with working with business staff on determining the funding needed for development of the Health Services Enterprise Portfolio. DHR in close partnership with Business Offices, manages the funding requests and reporting to the federal agencies – primarily CMS – providing funding. In addition, the Division continues to play its more traditional role in support of the expansion and funding of Health Information Technology (HIT) and Health Information Exchange (HIE), optimizing utilization of federal and state HIT resources.

AHS currently has an IT Governance structure in place that focuses on the changing business processes and IT systems that support coordination of benefits, claims processing, clinical care efforts, economic services, and Medicaid systems. This work group has been expanded to ensure that current and planned Medicaid and non-Medicaid IT projects which intersect with Vermont’s larger HIT and HIE initiatives will include interoperability and enterprise standards as required design elements for all involved initiatives. AHS has made it a priority to have the ‘right people’ at the table throughout the Portfolio efforts and therefore from day one, there are not only project and program managers but there’s also business office and finance staff, enterprise architect and data analysts, and senior leadership and commissioners. This allows for not only more consistent communication but it also creates the means to expedite decision making and the addressing of any issues that may arise.

The scope of Vermont’s Portfolio reaches across and beyond the Agency of Human Services as it encompasses the creation of a transformative and ‘learning health network’. One of the complexities of managing the scope of projects involved in the Health Services Enterprise is the high degree of overlap and interdependency between its constituent parts. This is true at the programmatic, policy, and business operations levels, as well as the technological infrastructure itself.

“Business as usual,” where the State managed both business functions and their related procurements in silos, was identified at the outset as a recipe for failure. Consequences could include deadlines not met or desired interoperability and functional integration not achieved.

Doing business in new ways raises new challenges.

Taking a more coherent, integrated approach to systems development and being inclusive of multiple Departments’ and individuals’ perspectives takes more thoughtful time and planning on the front end, but it can save time and rework during systems implementation and pay operational benefits well into the future.

A key element to that front end planning is deciding what to do and also what not to do: what order do we tackle the work, what work needs to be done now, what can be deferred until later? A key consideration, given the complexities of the systems, the crushing time frames, and the deadlines is: what is necessary to meet the state and federal statutory deadlines and how must the work be prioritized (incrementally) to meet project goals at each step?

One advantage inherent to a new, systemically integrated approach to design is that the components of the projects can be isolated and addressed discretely. Projects can be divided into manageable chunks. The challenge is to determine which “chunks” go together, and in what order. Two examples offer some perspective on what is involved.

1. Eligibility and Enrollment (E&E) systems. The non-health care aspects of E&E are being postponed until after the 1/1/14 Exchange launch date. That is, what AHS has described as the VIEWS (Vermont Interactive Eligibility Workflow System) project to replace the decades old ACCESS eligibility system has itself been divided into health related and non-health related components. That said, E&E is as essential a component of the Health Benefits Exchange as it is of Medicaid. Indeed, the E&E functionality for HIX and Medicaid represent nearly identical business processes. The difference is only in the beneficiary’s programmatic eligibility, and as is well known, beneficiary eligibility itself is often fluid, shifting from month to month as income levels shift. Therefore, that portion of the HIX infrastructure that is identical, or is nearly identical, to the Medicaid E&E infrastructure will be procured as a single component. That pairing of needs and technology will benefit both the procurement and on-going operations, as the Medicaid funding for E&E extends beyond the federal HIX funding horizon.
2. Web “portals” or web-based interfaces to the Health Services Enterprise components. These are significantly more complex than might initially be imagined, because there are potentially multiple users who can utilize portions of the same infrastructure, but for very different purposes. For economy of scale and ease of use, maintenance, and operation, it would be inefficient to create multiple portals (replicating the current environment). However, the users will differ substantially, and so certain aspects of the “look and feel” of the portal may change depending upon the role of that user.

Specifically, users will include: consumers, both those enrolled and those "still shopping," state staff and contractors, providers, and insurance carriers. It is important to think about how each type of user will interact with the system to ensure that the functions will work well for that type of user. Making those and other HIX design and procurement decisions still further complicated, Vermont has the opportunity (through the CCIO early innovator grant to NESCIES) to leverage Massachusetts' HIX portal procurement, but like the rest of the Massachusetts-related procurement leveraging opportunities, the fact that Vermont does not control Massachusetts' time frames represents a substantial risk.

Both examples illustrate how the portfolio of projects must be understood and managed from both a time sequence and functional process perspective. Through the portfolio roadmap work in the final quarter of 2011, the Division began to outline a series of Requests for Proposals (RFPs) to enable a cohesive and collaborative, organized and systemic process for procuring the services and components necessary for health IT transformation. This strategy allows for continued and nimble, layered procurements and implementations which enables the State to continue progress via a series of contracts and other partnerships that can bolster the capabilities of Vermont's Health Enterprise.

The first RFP in the Vermont Health Services Enterprise RFP series focuses on the Enterprise Master Persons Index (eMPI). It was released in January and will be quickly followed up with a request for implementing the Enterprise Services Bus (ESB); Health Portal; and/or Identity Management. Portfolio management of procurement will use this incremental process to allow for maximizing an individual RFP procurement while minimizing, to the extent possible, the time to implement parts of a solution.

- Subsequent RFPs will build out the components of:
  - the Health Benefits Exchange,
  - the Vermont Integrated Eligibility Workflow System (VIEWS), starting the replacement of the current ACCESS system with the health eligibility components that will support both Medicaid and the Exchange, and
  - the ten business areas included in the Medicaid Information Technology Architecture (MITA) that encompass the Medicaid Management Information System (MMIS).
- Where applicable, RFPs will combine solutions for multiple enterprise components. For instance, both Member Management and Provider Management have applicability for Medicaid and the Exchange.
- Either as a series or in a combination RFP, requirements to support VIEWS and the Exchange will be released as rapidly as possible in the winter into spring time frame. Sequencing of these RFPs is dependent upon a variety of factors, including how much can be leveraged from other state and federal efforts. For instance, Vermont may be able to take advantage of much of the Exchange infrastructure under development in Massachusetts, but the level of sharing of systems will determine the scope of the Exchange-related RFP.
  - In all instances, the RFPs will be for contractors who have the skills to integrate and implement systems which will build on the core AHS Enterprise IT components. In other words, while each

RFP is distinct, the products must work together to create an integrated information technology system.

- Planning and procurement processes will be designed to ensure that the following non-negotiable deadlines will be met:
  - Core E&E and HIX infrastructure must meet CMS approval 1/1/13
  - Core E&E and HIX infrastructure testing must begin no later than 7/1/13
  - Consumers should be able to view and "start shopping" on the Health Benefits Exchange no later than 10/1/13.
  - Health coverage – Medicaid and Exchange plans – available for consumer selection and enrollment no later than 1/1/14.

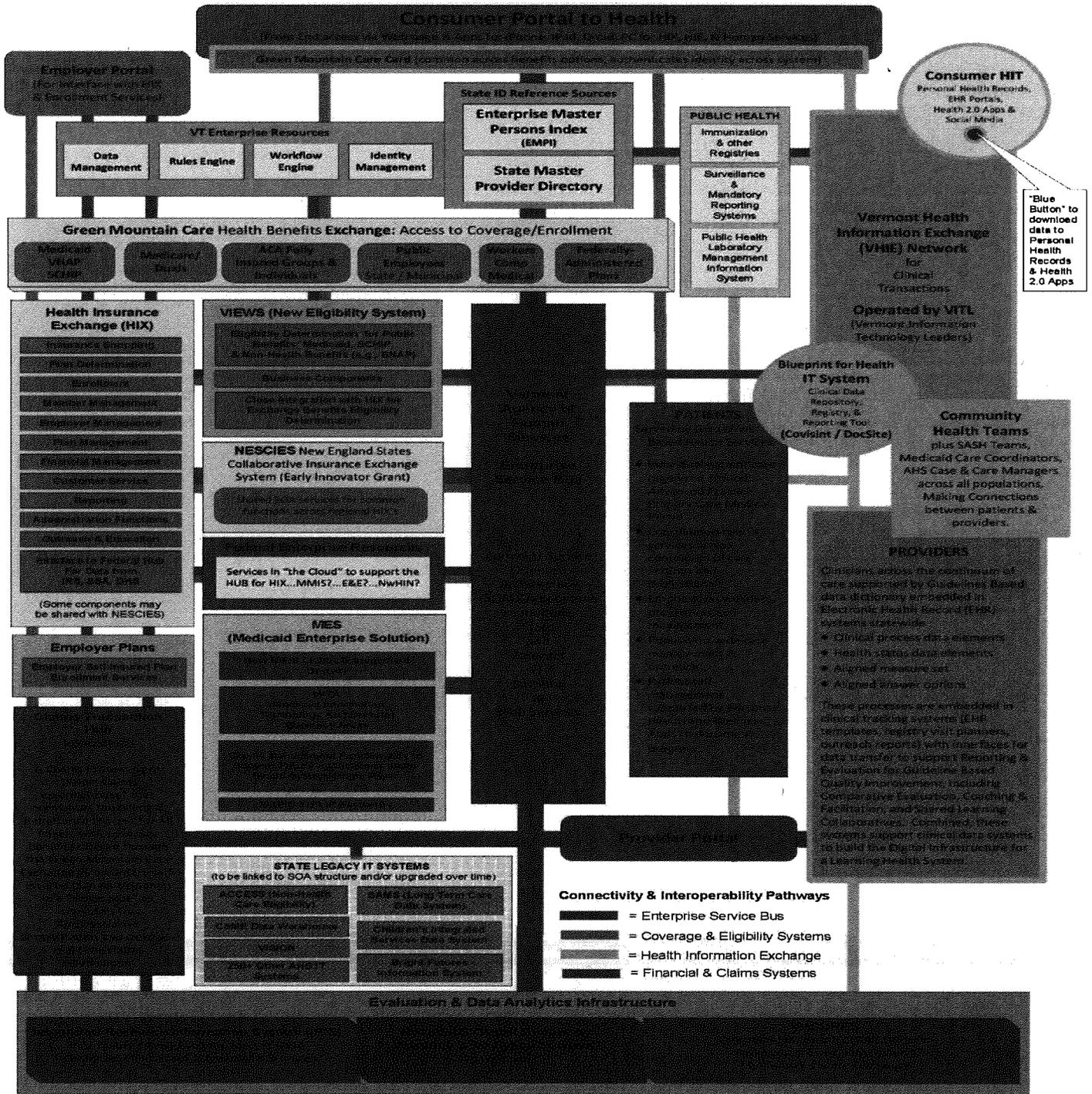
The scope of Vermont's health reform agenda requires a highly coordinated and integrated approach to health care statewide, with an emphasis on wellness, disease prevention, care coordination, care management, and a particular focus on primary care, with participation by all payers, including Medicaid. These efforts all lead to the State's over-arching goals to: transfer beneficiary and provider data timely and securely, enhance quality of health care delivery, improve health care outcomes, and reduce overall health care costs. The DHR oversees and coordinates all of the efforts involved with this integrated and robust environment.

Part of the purpose of this work is to comply with Federal regulations, CMS requirements and to continue to comply with best practices and industry standards. Another purpose in pursuing the project is the State's efforts to ensure access to more reliable, detailed, and less ambiguous health care environment that will enable better delivery of health services for the Medicaid eligible population. These efforts are provided in the most cost efficient and comprehensive manner possible and they will optimize the accessibility and quality of health care for the citizens of the State of Vermont.

The following three diagrams illustrate the magnitude of the Vermont Health Enterprise Portfolio. The first diagram demonstrates with a 'person-centric' view all of the connections and 'touch-points' that a 'user' of the system may have. The second diagram provides a 'thematic' view of the Enterprise based on aspects such as financial, clinical, eligibility, etc. The third diagram depicts a 'schematic' view of how the Enterprise is built-out in terms of our Health Information Exchange. These delineations represent the immense scope of the Portfolio in terms of the amount of the work involved (the impacted parties and partners) and also in terms of its importance (the user experience and data liquidity aspects).

# A Person Centered System of Health

VT Health Reform IT Architecture: Maximizing Federal Resources, Increasing Administrative Systems Efficiencies  
 NOTE: this is only a suggestive schematic, not a data flow diagram, and is only for discussion & conversation provoking purposes.

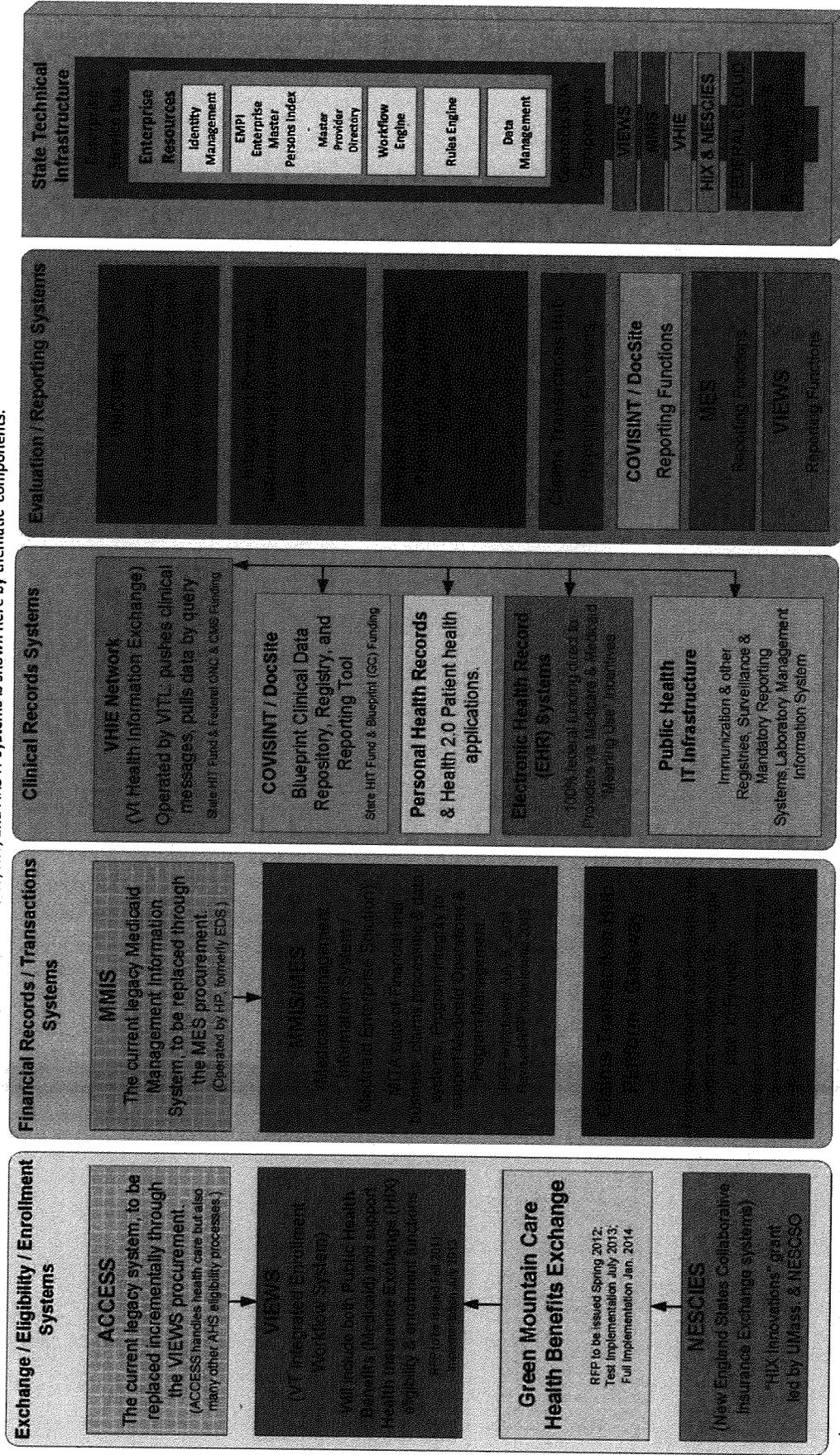


The newest version of the famous Vermont HIE/HIX Visio, is at least the tenth iteration of this visual representation of the interconnected systems design of the VT Health Reform IT & HIT Portfolio. This version starts with a new orientation: a person-centered "Portal to Health" supported by an Identity Management system enabling access to coverage options and to individual health information. It serves as the fundamental building block for the rest of the system, to ensure secure, authenticated Identity Management of both individuals and health care providers & professionals across the Portfolio infrastructure.



# Health Reform Information Technology – Health Information Technology – AHS Information Technology

The Portfolio of HR IT, HIT, and AHS IT systems is shown here by thematic components.



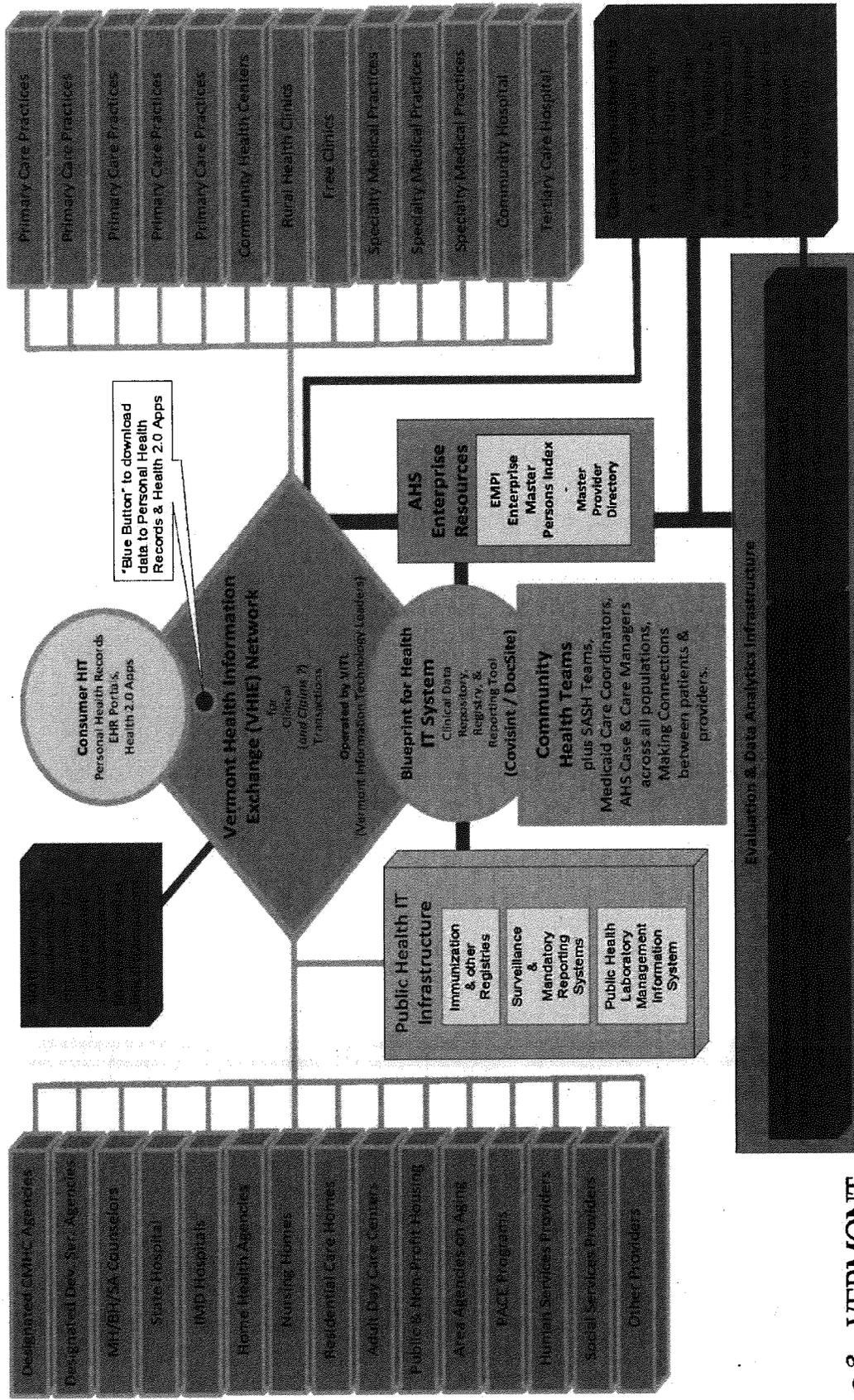
Legacy systems due to be replaced are shown with check pattern.





# Schematic View of Health Information Exchange eco-system

*This is not a data flow diagram – it is for illustration & discussion purposes*





### 3 Statement of Alternative Considerations

Federal mandates and HIPAA Rules are federal laws that specifically lay out the requirements for State Medicaid agencies. There is no alternative for a state but to implement the modifications, unless the final rule is rescinded or modified. At this time, for the State to meet its strategic goals and objectives and also meet CMS deadlines, we cannot further delay this work. The State would be at risk for losing valuable funding opportunities and more importantly, negatively impact the ability of beneficiaries and providers to access necessary health care services and information. The alternative of non-compliance was not considered by Vermont.

One alternative that is within the State's means would be to stagger each project submission individually. The goal of this "umbrella" submission is to streamline our health care reform projects into a holistic document that is intended to be easier for CMS and other stakeholders to understand. If the State were to submit approval documents for individual projects, they would not be linked together coherently and open room for more questions and confusion. Because of the strong links from one program to another, the value of the approval of one project or program may be significantly reduced or nonexistence if another is rejected (for technical or programmatic reasons.) The other logistical problem with this approach is that "staggering" the submissions will extend the approval process and further delay our initiatives. Thus the State does not foresee another clear consideration to pursue than the course it has undertaken.



## 4 Work Program Description

We acknowledge that in the process of developing this overarching I-APD document, we are informing CMS of initiatives that may or may not have already been described in material submitted prior in 2011. We will continue to describe our initiatives, but also try our best not to be redundant. There are a variety of project areas that are included in this submission, and will be categorized in the four following areas:

1. Core Components
2. Health Insurance Exchange (HIX) / Health Eligibility and Enrollment (E&E)
3. Medicaid Enterprise Service (MES)
4. State Medicaid HIT Plan (SMHP)

### **1. Core Components**

#### **Background**

The core components of Vermont's Health Enterprise encompass a series of projects and tools that have far reaching impacts into other areas of this I-APD. They create the foundational platform from which Vermont can build its shared services utilizing the latest technology in a transparent (product neutral) and agile fashion.

#### **Service Oriented Architecture (SOA)**

Vermont is in the midst of many initiatives to modernize not only its technology (systems, hardware, software, etc.) but also its business processes. The State seeks to modernize its infrastructure and be able to reap the benefits of SOA. These initiatives must include a full integration and work seamlessly with Vermont's HIT/HIE enterprise architecture. This involves ensuring Vermont's HIT/HIE architecture is prepared to interchange information with State systems where appropriate. Specifically, this includes developing and strengthening electronic interchange standards for HIE and ensuring that other HIT systems can interact reliably and securely with State data repositories. The State's Governance structure support coordination of benefits, claims processing, clinical care efforts, economic services, and Medicaid systems. This structure has been expanded to ensure that current and planned Medicaid and non-Medicaid IT projects which intersect with Vermont's larger HIT and HIE initiatives will include interoperability and enterprise standards as required design elements for all initiatives involved.

#### **Enterprise Master Person Index (eMPI)**

Vermont seeks to implement EMPI to identify, match, merge, de-duplicate, and cleanse patient records to create a master index that may be used to obtain a complete and single view of a patient. By correctly matching patient records from disparate systems and different organizations, a complete view of a patient will improve patient care, customer service, and the use of Electronic Health Records (EHR).

## Health Care Portal

The State desires a fully functional, user friendly, intuitive portal that connects the eMPI and Identity Management solutions to allow for login and accessibility features for users of the health care enterprise. The Portal will be created for the purposes of health care reform but will be scalable and expandable for possible future uses on non-Medicaid IT projects.

## Provider Directory

Vermont seeks to establish a health care Provider Directory to support management of health care provider information in an official capacity, a single source of information for the State. The Provider Directory will simplify and streamline information in regards to provider type, specialties, credentials, demographics and service locations.

## Imaging / Electronic Records Management (ERM) expansion

Vermont seeks to establish an electronic records management system that maintains the health related records of the Agency from the time the records are created up to their eventual disposal. This may include classifying, storing, securing, and destruction (or in some cases, archival preservation) of records. A record can be either a tangible object or digital information: for example, birth certificates, medical documents, office documents, databases, application data, and e-mail.

## Data Warehouse

The Central Source for Measurement and Evaluation (CSME) data is the existing data warehouse for Vermont's Agency of Human Services (AHS). Currently, this repository captures and presents information at an individual level. One of the objectives of the data warehouse is to provide a view of an individual across all departments, including all services, authorizations and programs.

Several functional system aspects of Health Information Technology (HIT) will eventually feed into or make use of data in the warehouse. The future requirements for tighter coupling of MMIS, Eligibility, HIX, Provider Directory and Master Person Index represents an opportunity to increase the value of the warehouse to its wide user base, while having it be an integrated source of information across HIT functions. Requirements to interface with CSME are included in both the MES (Medicaid Enterprise System) and Eligibility RFPs. As more sources of data are identified for inclusion in the warehouse, and as the warehouse becomes an integral component of the HIT architecture, the need to continue expanding and upgrading the CSME warehouse is apparent.

## Other facets of Core Components:

There are a number of additional pieces that make up the core components such as: Enterprise Resource Planning (ERP), Rules Engine (RE), Workflow Management (WF) and Enterprise Services Bus (ESB). These components along with the others above allow for sharing of information in a secure manner along

with determining what information is to be shared and in what manner. These components will work in conjunction with one another to allow secure and seamless transferring of information.

### **Work Description:**

Many of our initiatives are dependent on the establishment of these tools and projects. For example, the Exchange and MMIS system will not be able to function properly without the establishment of EMPI, Provider Directory, Data Warehouse, etc. This is continuing the theme echoed in other parts of the RFP that many of these initiatives are intrinsically involved with one another. Here is a Work Description for each project:

#### **Service Oriented Architecture (SOA)**

Vermont is actively in the process of the transition to modernize its technological components with the purchase of Oracle software products, and our consultant Accenture, for various AHS IT infrastructure initiatives. The basis for SOA is the flexibility and dynamic nature in which a robust platform can not only be installed but also expanded and built upon in a manner that expedites implementation times and impacts. Vermont has been currently focusing on certain core tools to be utilized with recent procurements centering on the Oracle suite of products. These tools are (with Oracle product names listed in parenthesis): eMPI (Master Data Management (MDM)), Identity Management, Enterprise Service Bus, Workflow Solution, and a Rules Engine (Oracle Policy Automation (OPA)). The State has been engaging (or will be) with vendors to partner with to implement and configure the SOA products and work towards their utilization in a production environment for health care.

#### **Enterprise Master Persons Index**

Vermont is currently in the process of selecting a vendor to help establish a statewide eMPI for health care. This is one of the first and key steps to identifying who a person is and what information we may have for them across the State. It's the critical piece for identifying a person's complete health care record which will establish a foundation to expand upon for identifying a person's needs and benefits across the Vermont.

#### **Health Care Portal**

The State continues to design and architect its Enterprise, the existence of the Health Care Portal is imperative. The State will be releasing an RFP to procure services to develop this portal in a scalable fashion to meet the needs of the HIX, E&E and MES and possible future uses on non-Medicaid IT projects

#### **Provider Directory**

We have engaged a consultant to identify data sources and uses throughout the state (State government agencies as well as other associations and organizations), to develop requirements for the Vermont State Provider Directory (VSPD), and to specify the design of an initial version (prototype). The establishment of

a Provider Directory is a challenging but essential activity in the To-Be landscape of HIT. It is essential to the Medicaid Enterprise Solution (MES) effectiveness and to the functional operation of the VHIE and the HIX. Vermont's State HIT Coordinator has participated in the development of recommendations from the Provider Directory task force to the Office of the National Coordinator (ONC) Policy Committee, and we continue to follow the federal dialog with interest. Funding requested in this IAPD will be used for the Design, Development, Implementation and ongoing support and enhancement of the VSPD. Because of the dual support function of the VSPD for both Medicaid and VHIE operations, it is appropriate to use a combination of Medicaid and ARRA/HITECH funding for this work.

#### Imaging / Electronic Records Management (ERM) expansion

Vermont is finalizing its requirements for this work and will be releasing a future RFP to procure services to provide for this work. The exact timing of this RFP is not yet known though the bigger picture of where it falls into place is apparent on the timeline in Section 8.

#### Data Warehouse

Vermont is finalizing its requirements for this work and will be releasing a future RFP to procure services to provide for this work. The exact timing of this RFP is not yet known though the bigger picture of where it falls into place is apparent on the timeline in Section 8.

#### Other facets of Core Components:

Some of this work, such as ESB and RE efforts, is underway but for the most part Vermont continues to finalize the requirements for these components and will be releasing future RFPs to procure services to provide for address these needs. The exact times of these RFPs and how they are structured (Can some of the work for different components be combined in one RFP?) are not yet known though the bigger picture of where they fall into place is displayed on the timeline in Section 8.

## **2. Health Insurance Exchange (HIX) / Health Eligibility and Enrollment (E&E)**

### **Background**

Our Health Enterprise vision ties in the establishment of Vermont's Health Benefits Exchange with our longstanding Eligibility and Enrollment project. Vermont has used funds from the federal Exchange Planning Grant received on 10/1/10 to complete a number of reports and engage stakeholders in the process of establishing an Exchange. Since this planning grant, we were awarded a Level 1 Exchange grant in 2011 that has allowed us to select Vendors to help define our program, including Wakely Consulting Group, who will assist with the second year of planning, designing, and developing Vermont's Health Benefits Exchange. The grant also provides a number of positions within the State to help implement and operate the Exchange. The first iteration of a plan for a new Eligibility & Enrollment (E&E) system, sometimes known as VIEWS (the Vermont Integrated Eligibility Workflow System), was completed in 2009; however, an RFP for VIEWS was not issued as it became clear that the plan would need to be modified to reflect the emerging vision for an integrated Agency IT architectural framework.

Release of the VIEWS RFP was subsequently further delayed by the passage of the ACA and Vermont's assessment of the opportunity to integrate a new E&E system with the Exchange. By early 2010, prior to passage of the ACA, a comprehensive "to be" vision of AHS IT infrastructure had emerged that included a modular, integrated platform. Passage of ACA and the opportunity to integrate the Exchange with Medicaid and VIEWS further solidified the integrated Enterprise framework approach

### **Work Description**

Vermont is in the process of hiring numerous positions associated with our Exchange initiatives, and will continue to do so over the course of two years until start-up of the Exchange in the fall of 2013. Vermont would like to develop a comprehensive integration strategy, including how to fully integrate or align Medicaid, the Medicaid-Medicare dual eligible demonstration, private insurance, associations, and coverage for State and municipal employees. Vermont has a clearly articulated vision for a comprehensively integrated Enterprise Architecture that will leverage IT investments across the Agency of Human Services. There are many open questions about the larger Exchange IT ecosystem, particularly with respect to the federal data hub, the State has and will continue to engage vigorously with HHS, CCIO and NESCIES colleagues, along with conducting an extensive internal planning process, to chart a clear path for implementation of the Exchange IT infrastructure. Because of Vermont's integrated SOA approach to AHS systems and the timing of the SOA core components implementation, as well as the Health E&E and MES procurements, the State has a unique opportunity to ensure maximum leverage and integration across the Health Reform and Health IT Portfolio components. Procedures for an independent, external audit, fraud detection, and reporting to HHS on efforts to prevent waste, fraud, and abuse will be established. A contractor will also ensure that program integrity functions are aligned between Medicaid and the Exchange to the extent allowable under federal law.

Vermont proposes to use its Health Care Ombudsman (HCO) program to provide assistance to individuals and small businesses. The HCO, which is part of Vermont Legal Aid, Inc., is an existing health insurance consumer assistance program with many years of experience in helping State residents resolve problems, answer questions, file complaints and appeals, and enroll in State health care programs. Vermont plans to use the HCO to provide these services for the Exchange. Since the HCO has been collecting data on consumer problems for almost twelve years, these data can be an important resource to inform the Exchange of the types of health insurance questions and problems that consumers encounter. We are asking for funding for the HCO to develop an implementation plan and educational materials for consumers.

Vermont seeks to explore design and functionality options for a Universal Exchange that serves all Vermonters on a mandatory or voluntary basis. We will develop planning and analysis capacity to determine which functions of an Exchange could be shared with payers who are self-insured or insured in

the large group market, as well as other coverage programs. The options and analysis will be made available to interested states and others outside of Vermont.

Vermont's need for call center functionality is vital to providing a "21st century" consumer experience for users of the Health Enterprise. The State currently has a number of call centers but there needs to be a substantial investment in terms of financial and human capital to address health reform needs in this area.

Vermont continues to work with CMS on the next steps to move ahead with procuring a new Eligibility and Enrollment System (E&E). The State continues to work with NE States as part of NESCSO/UMASS efforts and make a decision on how we can leverage and "link" our work in Eligibility with Vermont's Insurance Exchange efforts. Staff will continue to learn about the SOA components and how to best utilize them for providing shared services, and how this works in conjunction with E&E needs.

### **3. Medicaid Enterprise Service (MES)**

#### **Background**

This program formerly known as the Medicaid Management Information System (MMIS) fiscal agent services and contract, is now referred to as Medicaid Enterprise Solution (MES). The State of Vermont was awarded a P-APD in 2011 for costs associated with planning and re-procurement of our MMIS provider in the hopes of upgrading our technology to industry standards, and ensuring that we are utilizing the most efficient and effective means of processing health care service claims.

#### **Work Description**

Vermont will continue to work with CMS on the next steps to move ahead with procuring a new MES, and follow an approach that incorporates the Seven Standards and Conditions for the program, and MITA 3.0. See Section 10 for more information regarding CMS' 7 S&C.

As discussed earlier, the Vermont Portfolio Planning activities include the building out of Vermont's Health Enterprise. Some of the activities cut across many boundaries including E&E, MES, and HIX. Other Vermont MES work that may/may not also address E&E and HIX needs includes procuring a vendor to improve Program Integrity, Contract Management, Case/Care Management and Operational Management. This work will provide drastic improvements in program integrity, functionality, vendor/contractor management and bring our program into the 21<sup>st</sup> century to meet industry standards. Related work such as ICD-10, 5010 and National Correct Coding Initiative (NCCI) are currently underway and have their own APDs for funding but are brought to your attention to identify them as additional/related activities.

### **4. State Medicaid HIT Plan (SMHP)**

## **Background**

In 2010 we received P-APD funds to support planning for HIT initiatives, and funds supported salaries for HIT related staff. This has been fully expended, and the SMHP-I-APD was approved in 2011 for further support of Vermont HIT staff as well as several individual projects within the HIT landscape:

### **MAPIR Application Development and EHRIP Implementation**

This application is known as the Medical Assistance Provider Incentive Repository (MAPIR). Providers who wish to receive Federal Electronic Health Record (EHR) Incentive Payments (EHRIP) payment from the State of Vermont will need to register at the federal level and submit an application to the State. The MAPIR system is a stand-alone, web-based application capable of interfacing with any MMIS system. The application will be phased-in over a period of two years and will have the flexibility to be modified to accommodate the reporting of new meaningful use criteria as CMS expands the requirements over the course of the incentive program.

It is important to note that the EHR incentive payments are directly involved with programs within the SMHP, but is not directly contained within the submission. EHRIP is a federal program that will be addressed outside of the realm of this I-APD.

### **VHIE Expansion**

The VHIE: Plays a significant role in the collection of Medicaid providers' meaningful use attestations and clinical quality measure data; Is directly focused on enabling providers to meet meaningful use requirements, such as lab results and clinical summary exchange; Provides immediate value to providers through affordable services that help them meet meaningful use requirements and coordinate and improve patient care; Is governed by state-level policies...and exchange standards that are aligned with Federal policy; and Is actively engaged with State government.

In Vermont, the HIE functions directly related to Medicaid Information Technology Architecture (MITA) business services and are necessary to enable them. Both a State Provider Directory and an Enterprise Master Persons Index, both identified earlier in the 'Core Components' section will, when fully implemented, serve as the authoritative, statewide reference sources for the VHIE, as well as for MMIS, the health care Eligibility and Enrollment system, and the State Health Insurance Exchange. The VHIE will support the transport of both clinical and financial data transactions, as well as electronic health care eligibility queries, effectively functioning as an extension of the State's Medicaid enterprise infrastructure. Significantly, the VHIE will provide this connectivity not just for eligible professionals and eligible hospitals, but for all Medicaid providers in the state, ultimately including long term care, home health, mental health and substance abuse services.

### **E-Prescribing**

A program, ePrescribe Vermont, offered through the Vermont Information Technology Leaders, Inc. (VITL), the State's HIE, provides a statewide license for prescribers without EHRs to use a free-standing e-prescribing application, provided incentives to providers with EHRs to implement e-prescribing functionality, and provides support to independent pharmacies in the state to accept and transmit electronic prescriptions.

The direct health benefits of e-Rx are well documented, but include medication safety advantages, increased system efficiency and reduction in routine problem orders which allows the pharmacist to focus on more clinically significant medication interventions, and patient satisfaction associated with turnaround time on orders. There are similar benefits to the primary care provider to be able to quickly obtain a current medication history for any particular patient, and support for medication histories is included in this funding request. e-Rx is a key aspect of Meaningful Use and this initiative in Vermont is consistent with our HIT roadmap goals of fully realizing the benefits of Meaningful Use for improved health outcomes, with lower costs. Consequently the State considers this an appropriate candidate for HITECH funding at the 90% level

#### Public Health IT

SMHP related Public Health IT begins with establishing the connection of Vermont Department of Health (VDH) end points with the VHIE, including the identification of data elements and associated mapping for the repository. The state's Immunization Registry will be enhanced to better serve its function. The flow of syndromic surveillance and notifiable lab results through the VHIE will be implemented. Also, Public Health Prevention Teams will be linked to the clinical data repository to support their reporting and analysis needs.

The Vermont Department of Health (VDH) will focus on enhancing the infrastructure necessary for users of electronic health records (EHRs) to demonstrate the two-way information exchange between the providers and the public health department. In addition, the activities will also allow for bi-directional information exchange between VDH information systems and other entities such as the MES.

#### Telemedicine and Videoconferencing Development

Vermont, though geographically small compared to most other states, is almost entirely rural in nature and features a rugged terrain and a challenging winter climate. As discussed in several places in Vermont's SMHP, telemedicine and video conferencing can play a major role in providing services to long term and primary care clients and patients. Telemedicine is a part of the mental health delivery strategic vision. It is also included in the strategic vision for long term and home health care. Additionally, telemedicine is seen as essential to fully realizing the benefits of Vermont's Blueprint for Health program (patient-centered medical home), as it could be utilized by both primary care practices and the community health teams now being established to coordinate services beyond the primary care practice domain.

## **Work Description**

### **MAPIR Development and EHRIP Implementation:**

We are making final decisions related to web portal content options and any workflow adjustments, and HP has moved into their development phase. HP had previously developed a high level scope and custom estimate for Vermont detailing the Statement of Work (SOW) for this effort. A comprehensive Testing Phase will take place to be certain that the MAPIR and MMIS systems are properly interfaced for incentive payment registration, attestation, payment and administration. This testing will include the requisite interface testing to the National Registration and Attestation System.

In addition to the development and customization work included in this IAPD, we are also including funding requirements to support the development of the EHRIP program in Vermont. This includes establishing procedures for the oversight and administration of the program, including auditing, establishing an EHRIP provider relations function, ongoing maintenance of the web portal content, reporting, and administrative assistance to program management. As we move into the actual EHRIP program we will identify any additional work that would require us to submit an amendment to this IAPD for the unanticipated work.

Future MAPIR core development will include the accommodation of Meaningful Use Stages 2 and 3, as well as more routine maintenance and enhancement updates. As core MAPIR releases occur, Vermont will have an ongoing need to meet those releases with customization work for the Vermont provider portal and the MAPIR interfaces to the MMIS. Implementing our EHRIP will help Vermont meet its strategic goals and objectives of enhancing our providers' capabilities to achieve the meaningful use of EHR technology. In addition to developing the MAPIR-related technical support for EHRIP our strategy also includes promoting the EHRIP to maximize participation and working closely with VITL (in both its HIE and REC functionalities) to facilitate the adoption of EHRs and the development of Health Information Exchange and Electronic Data Sharing.

### **VHIE Expansion:**

The State of Vermont has a unique funding mechanism to ensure all payers contribute an appropriate share of the costs of operating its HIT-HIE infrastructure, its Health Care Information Technology Reinvestment Fee, enacted as 8 V.S.A. § 4089k. The fee collects "0.199 of one percent of all health insurance claims paid by the health insurer for its Vermont members in the previous fiscal year" which are deposited in the Health IT Fund. The fee applies to all carriers with over 200 covered lives in the state. The State of Vermont submits that this statutory requirement meets the requirement for "legal agreements with HIE partners" stipulated in SMDL# 11-004.

We have had discussions with CMS on the particular application of this reinvestment fee and the administrative details of assessing this fee. We currently assess this fee on payers who have more than 200 covered lives in Vermont, A concern was raised by CMS that this fee may be considered a tax and, if

so, was not being applied uniformly to all members of the taxed "class". That concern was predicated on the interpretation that these payers are considered healthcare providers as described in 42 CFR Part 233.56. We believe this concern has been resolved and the current interpretation is that these payers are not considered healthcare providers, as they do not operate clinics or in any other way provide direct medical attention. With this interpretation, Vermont is not required to obtain a waiver to continue recognizing a threshold of 200 covered lives before imposing its HIT Reinvestment Fee.

As such, the State can ensure that Vermont Medicaid meets the cost allocation principles, as defined by OMB Circular A-87, where entities other than the Medicaid agency stand to benefit in the results of HIE activity. A primary purpose of the Health IT Fund is to support the costs of operating the Vermont Health Information Exchange (VHIE) network by Vermont Information Technology Leaders, Inc. (VITL) and to ensure that all Vermont providers establish and have on-going connectivity to the VHIE. 18 V.S.A. chapter 219 § 9352 designates VITL, a private, non-profit corporation, as the exclusive operator of statewide HIE for Vermont

In Vermont, the HIE functions directly relate to MITA business services and are necessary to enable them. Both a State Provider Directory and an Enterprise Master Persons Index will (when fully implemented) serve as the authoritative, statewide reference sources for the VHIE, as well as for MMIS, Provider Management, Member Management, the health care Eligibility and Enrollment system, and the State Health Insurance Exchange. The VHIE will support the transport of both clinical and financial data transactions, as well as electronic health care eligibility queries, effectively functioning as an extension of the State's Medicaid enterprise infrastructure. Significantly, the VHIE will provide this connectivity not just for eligible professionals and eligible hospitals, but for all Medicaid providers in the state, ultimately including long term care, home health, mental health and substance abuse services.

#### E-Prescribing

The Department of Vermont Health Access has worked with its Pharmacy Benefits Manager, MedMetrics Health Partners, to further analyze the e-prescribing landscape in Vermont and have identified an initiative to remove a major hurdle to a wider implementation of e-Rx – the transaction fees associated with each e-prescribing activity. The State estimates that the cost of the state to absorb these transaction fees would be approximately \$150,000 in State Fiscal Year 2012, and \$250,000 in SFY 2013. This IAPD includes a request for \$460,000 in FFP assistance to cover the period from July 1, 2011 through September 30, 2013 in support of this initiative. We will reevaluate the need to extend this transaction subsidy beyond FFY 2013. However, we anticipate that we will want to extend this start-up support for e-prescribing for 4-5 years and will request additional funding in future updates to this IAPD. To better define a transition point between the start-up and operational status of this program, we propose that such a transition occurs when 75% of prescriptions are being presented and processed electronically.

#### Public Health IT

Electronic reporting of notifiable diseases will be expanded to all 14 Vermont hospital-based labs. VDH uses the Centers for Disease Control and Prevention's (CDC) National Electronic Disease Surveillance System (NEDSS) Base System for the tracking of reportable diseases. The department receives laboratory test results on paper weekly from the hospital-based labs in Vermont. These reports are manually data entered into the NEDSS system. The NEDSS system is capable of receiving electronic laboratory reports (ELRs) using a HL7 standard message and ELRs are received daily from the national reference labs, Mayo and LabCorp. Work has started with one Vermont hospital lab and, to date; lab reports for approximately ten diseases are being received electronically daily.

The VDH Immunization Registry is being modified to accept immunization reports in HL7 format via Vermont's Health Information Exchange (HIE) operated by the Vermont Information Technology Leaders (VITL) eliminating the need for duplicate data entry by providers. Once this is accomplished, the focus will be on the bi-directional aspect of data exchange by eliminating the need for providers to log into the registry in order to print immunization histories for their patients, check the immunization forecaster for shot guidance, or run vaccine coverage reports for their practice

No activities will be undertaken during year 1 for Syndromic Surveillance. The department currently uses an application provided by the CDC, the Early Aberration Reporting System (EARS), to process files that contain reports of Emergency Department visits from hospitals. The files are not in HL7 format. The VDH does not plan to modify this application in-house but will monitor CDC's support of the application. Funding in this IAPD will support the necessary requirements gathering, design, development and implementation of these public health initiatives. Since there are also data feeds required to VDH from the MMIS system, allocating the funding from Medicaid and HITECH is appropriate.

#### Telemedicine and Videoconferencing Development

Several broadband initiatives are underway in the State, and our telemedicine strategies must be coordinated with these efforts, while also considering the change management aspects of health care delivery via broadband connectivity. Videoconferencing can also be used to improve the effectiveness of Health care delivery by supporting administrative and coordination services in addition to interactive patient encounters. The SMHP and the State HIT Plan identify the need to leverage disparate HHS, ARRA, and health reform resources that can be brought together to implement a unified, operational framework. Full health care system integration in Vermont means integrated care delivery with HIT connectivity and interoperable HIE systems and telemedicine via statewide broadband to all providers and health care institutions.

## 5 Cost Benefit Analysis

Federal agencies are directed to assess all costs and benefits of available regulatory alternatives and to select approaches that maximize net benefits. The State of Vermont, the Agency of Human Services, and in particular, the Department of Vermont Health Access has examined the impacts of these changes for the Medicaid program in proposed state rules and, as stated above, has determined that there is no viable option except implementation of the proposed changes. Many of the initiatives in this I-APD involve upgrades to IT system infrastructure and other technological upgrades that will replace archaic systems and provide increased efficiency and cost savings. In addition to the improvement of our healthcare system, technologies within this I-APD will save costs over the course of their use. State employees have done their diligence in pursuing sound strategies that will be an effective use of taxpayer dollars. No further cost-benefit analysis has been performed.

State management, professional, and systems staff will be drawn from AHS positions including those requested as part of this IAPD. Staff costs will be distributed according to the time personnel devote to this project. Vermont has in place an accounting system to report, track and credit time/work to the appropriate accounts and will be reported under the federally approved cost allocation plan.

## 6 Personnel Resource Statement

The Health Enterprise Portfolio project has enterprise-wide impacts and Vermont's efforts rely on a strong governance team (Division of Health Reform) lead by Hunt Blair, Deputy Commissioner of the Department of Vermont Health Access (DVHA), and State Health Information Technology (HIT) Coordinator. Mr. Blair's role will be to coordinate and guide the project across the Agency. Mr. Blair has strong relationships on the State and Federal level that will enable the State to gain support and investment throughout the course of the project.

The project team will be comprised of many Agency of Human Services (AHS) staff including additional staff identified as part of certain procurements. While each procurement/activity will have different subject matter experts (SME) they will also have a certain 'standard' team in terms of resources and those are identified below. These resourcing roles may be filled by State resources (full and/or limited service positions) or via contracts/grants. The accompanying spreadsheet has additional information in a timeline format combined with financial information, and is also referenced in Section 11 of this APD.

Thus each component would have a 'team' of staff (with some overlapping duties) but structured in the following way:

Who	Health Staffing	Internal Staff Or Contractual equivalent
DVHA	Contract Manager	0.2
DII	Project Manager	2
DII	Enterprise Architect	4
DVHA	Business Architect	2
DVHA	Technical Lead SOA	12.5
Direct in Grants	Financial Analysts	1
Direct in Grants	Subject Matter Experts	5
Direct in Grants	Data Warehouse	2
30% of DII costs	Project Change Management Contracts	
DVHA	Portfolio Change Management Contracts	14
Direct In Grants	Policy Analysts	2
10% of DDI costs	QA (Code Review)	
5% of DDI costs	IV&V	
3% of DDI costs	DII Project Management Costs	
<b>Total</b>		<b>44.7</b>

## 7 Description of Activities

Vermont has undertaken a number of activities to address the needs of this project. Refer to Section 8 for specific activities and timelines/milestones. In general, here are some of the activities that may or may not have been identified elsewhere in this APD:

- Some activities include some ongoing work where staff documented the scope of the end-to-end process from 'identifying a need' through 'addressing the need (procurement)' that has already produced some efficiencies such as:
  - Enhancement of the process to review, edit and modify RFPs to expedite their posting, and the
  - Enhancing the process to review and sign-off on contracts to expedite their approval
- Vermont has partnered with The Action Mill to work on change management activities in terms of clearly identifying what needs to be done, who's involved, how and when do we communicate, etc. This work has enabled the State to have a clearer vision of how Vermont will stagger RFPs, allocate resources, fund activities and ultimately, create an integrated, functionally rich, scalable, secure, modular Learning Health Network.
- Established a health care IT Stakeholders Committee, to review and plan the various health care IT activities, that includes the Vermont CIO, Vermont Deputy CIO, AHS CIO, AHS Deputy CIO, SOA Team Manager, State IT Architect, Vermont HIT Coordinator, and Vermont Data Architect among others.
- Established a health reform business Stakeholders Committee, to review and plan the overall goals of the health reform work, that includes the Agency Secretary, Agency Deputy Secretary, AHS CIO, Vermont HIT Coordinator, and Vermont CIO among others.
- Created a business process team that has been documenting Vermont's current workflow for E&E and identifying certain changes that will be needed as part of ACA.
- Vermont will issue a series of RFPs to address the services that are needed to meet Vermont's vision for a Learning Health Network.
- There is continued focus on expansion of the Blueprint for Health including participation in the Multi-payer Advanced Primary Care Practice demonstration and the AHS Dual's project.
- Detailing the process by which the State will build the Health Care Enterprise through sequential RFPs.
- Subsequent RFPs will build out the components and address the needs of:
  - Health Insurance Exchange,

- Health Eligibility and Enrollment System which begins the replacement of the current ACCESS system, and
- Medicaid Information Technology Architecture (MITA) business areas along with meeting the needs of the Medicaid Enterprise Solution (MES).
  - Where applicable, RFPs will combine solutions for multiple enterprise components. For instance, both Member Management and Provider Management have applicability for Medicaid and the Exchange.
  - Either as a series or in a combination RFP, requirements to support VIEWS and the Exchange will be released as rapidly as possible in the winter into spring time frame. Sequencing of these RFPs is dependent upon a variety of factors, including how much can be leveraged from other state and federal efforts. For instance, Vermont may be able to take advantage of much of the Exchange infrastructure under development in Massachusetts, but the level of sharing of systems will determine the scope of the Exchange-related RFP.
  - In all instances, the RFPs will be for contractors who have the skills to integrate and implement systems which will build on the core AHS Enterprise IT components. In other words, while each RFP is distinct, the products must work together to create an integrated information technology system.
  - Planning and procurement processes will be designed to ensure that the following non-negotiable deadlines will be met:
    - Core E&E and HIX infrastructure must meet CMS approval 1/1/13
    - Core E&E and HIX infrastructure testing must begin no later than 7/1/13
    - Consumers should be able to view and “start shopping” on the Health Benefits Exchange no later than 10/1/13.
    - Health coverage – Medicaid and Exchange plans – available for consumer selection and enrollment no later than 1/1/14.
- Refer to Section 11 (Prospective Cost Distribution) and to the accompanying spreadsheet, *Vermont\_Health\_Enterprise\_Budget\_v4*, for additional information that lists out the activities/work efforts that will be taking place.





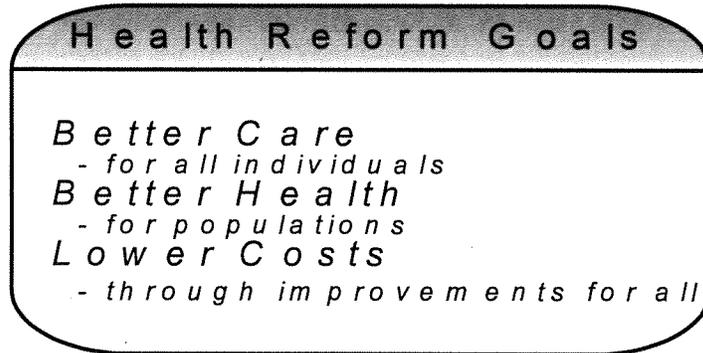


## 9 Proposed Budget

Refer to the accompanying spreadsheet, *Vermont\_Health\_Enterprise\_Budget\_v4* for a detailed budget breakout of our Health Enterprise plan. A description of each tab can be found in Section 11 of this APD.

## 10 Statement of Expected Usefulness

The period of expected usefulness is from the date of implementation, and will be on-going as this is the implementation of a Learning Health Network. It will function as a continuously growing, expanding, and iterative environment that emits enhanced utilization the more it is used. It reflects advances in medical technology, data information and knowledge/innovation.



The following table contains information about how VT's Health Enterprise plans, supported under this IAPD, are aligned with the 7 standards and conditions in 42 CFR Part 433. The State has developed a chart that describes how its proposed solutions will meet each of the 7 standards and conditions and how the State will ensure that the HIT-related systems are integrated within the total Medicaid IT enterprise, as appropriate, rather than being a stand-alone system. This provides a view into the 'usefulness' of the Enterprise to all of those exposed to the Enterprise.

Comments Specific to this IAPD	Comments for Vermont Plan	Comments Specific to this IAPD
<p>The MAPIR application incorporates the capability to interface with both the National Registration and Attestation system and with Vermont's MES system utilizing messages that are processed in real or near-real time. The Public Health application and the Provider Directory application described in the IAPD follow the State's current waterfall system development methodology. The Provider Directory is an example that will be developed making use of the Core Components.</p>	<p>Vermont has recognized the need for the introduction of appropriate components to support modularity in its approach to introducing new systems. The State has completed the procurement process for Service Oriented Architecture (SOA) core components which reflects a transformation in Vermont's approach to system development that is aligned with the Modularity Standard. It is important to note that the core components procurement was initiated prior to requirements related to an Insurance Exchange, but, significantly, were procured with the procurement of a new eligibility system in mind that is flexible, scalable and modular to take advantage of newer technologies.</p>	<p>1) Modularity Standard</p> <ul style="list-style-type: none"> <li>• Modular flexible approach to systems development;</li> <li>• Use of open interfaces and exposed APIs;</li> <li>• Separation of business rules from core programming;</li> <li>• Formal system development methodology;</li> <li>• Open reusable system architecture;</li> <li>• Submission of business rules to an HHS-designated repository.</li> </ul>
<p>Vermont, as depicted in this IAPD, is implementing an architecture that aligns with the MITA strategy and guidelines. The SMHP program is one of the first of many initiatives to be completed that will lead Vermont in providing a robust, automated and 21<sup>st</sup> century experience within our health care enterprise environment.</p>	<p>Vermont is prepared to initiate a second MITA self-assessment within 12 months of the release of the MITA 3.0 standard. The SOA core components procurement discussed in item 1 above was initiated in large part as a response to the low maturity level documented in the first MITA assessment. The State recently halted its Medicaid Enterprise System procurement because it was felt that the responses to the MITA considerations in that RFP were insufficient. The RFP will be revised to place the proper emphasis on this area and a new procurement cycle will be initiated. Perhaps the decision to redo the RFP is itself a sign of MITA-influenced maturity.</p>	<p>2) MITA Condition</p> <ul style="list-style-type: none"> <li>• Align and advance increasingly in MITA maturity (business, architecture, data);</li> <li>• Measurable progress in MITA roadmap;</li> <li>• Update MITA self assessment;</li> <li>• Provide a MITA Maturity Model Roadmap;</li> <li>• Concept of operations and business work flows.</li> </ul>
<p>All of the work proposed in this IAPD is being undertaken with a commitment to maintaining or implementing the appropriate industry standards, especially including HIPAA, Section 508 accessibility</p>	<p>Vermont is aware of and is following HIPAA standards and the section 508 accessibility standards. Standards and protocols described in sections 1104 and 1561 of the Affordable Care Act are reflected in the development of an</p>	<p>3) Industry Standards Condition</p> <ul style="list-style-type: none"> <li>• HIPAA Standards;</li> <li>• Accessibility standards in section 508 of the Rehabilitation Act;</li> </ul>

<ul style="list-style-type: none"> <li>Standards under section 1104 of the Affordable Care Act;</li> <li>Standards and protocols under section 1561 of the Affordable Care Act.</li> </ul>	<p>Insurance Exchange currently being developed as a multi-state collaboration funded by an Early Innovator Grant. The State also has the document and appendices released by the Secretary as recommendations for Section 1561 of the ACA. In addition, the State is aware of and giving consideration to the requirements of 4201 Part II of the HITECH Act.</p>	<p>standards, and HITECH 4201 Part II.</p>
<p>4) Leverage Condition</p> <p>Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states:</p> <ul style="list-style-type: none"> <li>Multi-state efforts;</li> <li>Availability for reuse – make artifacts available to a repository;</li> <li>Identification of open source, cloud-based and commercial products – service-based and cloud-first strategy;</li> <li>Off-the shelf or open source;</li> <li>Identify customization and how it will be minimized;</li> <li>Transition and retirement plans of duplicative systems services.</li> </ul>	<p>Vermont is one of the New England states participating in an Early Innovator Grant to develop an Insurance Exchange for Massachusetts. The collaboration is fully engaged in insuring the sharing and leveraging of this development, which is being done following the Modularity Standard. The State expects to obtain components and/or system and process details and requirements from this effort. This information will provide an advanced basis for the completion of a Vermont insurance exchange. Vermont participates as an Early Innovator state in the CALT cloud environment, but has not had an opportunity to submit any artifacts to that repository.</p>	<p>The MAPIR application, included as part of the EHRIP program portion of this IAPD, is an excellent example of multi-state collaboration resulting in core functionality readily shared and leveraged by the participating states (and available to other states as well). The use of the common core development allows for minimal customization for Vermont's Medicaid instance, as reflected in the modest price of that effort.</p>
<p>5) Business Results condition</p> <ul style="list-style-type: none"> <li>Degree of automation in systematic processing of claims;</li> <li>21<sup>st</sup> century customer service and partner experience for all individuals, with web and self-management features;</li> <li>Performance standards and testing – Service Level Agreements (SLA) and Key Performance Indicators (KPI).</li> </ul>	<p>The Medicaid Enterprise System procurement has automation in the systemic processing of claims as a requirement, including performance standards.</p> <p>The Early Innovator State insurance exchange grant development includes a development requirement for a 21<sup>st</sup>-century customer service experience, and includes web and self-management features.</p> <p>Vermont's eligibility system RFP, soon to be released, also addresses the Business Results</p>	<p>Vermont's implementation of its EHRIP technology provides for a semi-automated processing of provider attestations. The State is deliberately pending attestations to introduce a pre-payment check of provider submitted data, to test for a reasonable match with State data sources (additionally, a post-payment statistically reliable audit program will be implemented). The MAPIR system application allows for a degree of self-</p>

	condition.	management in its web-based implementation; providers can avail themselves of summary lists at any point in the process, can easily mark their progress, and can save and return to the system and their attestation at any time prior to final submission of a claim attestation.
<p>6) Reporting Condition</p> <ul style="list-style-type: none"> <li>• Produce transaction data, reports and performance information;</li> <li>• Electronically expose accurate data for oversight, administration, evaluation, integrity, and transparency;</li> <li>• Automatically generated through open interfaces to federal repositories or data hubs, with audit trails.</li> </ul>	<p>The Reporting condition is reflected in the MES procurement requirements, as it will be in the Eligibility procurement. The condition aspect of automatic generation through open interfaces to federal repositories and hubs will be addressed as more refined guidance becomes available from CMS. However, the Early Innovator State insurance exchange project is likely to be an early example of working with a federal data hub to make this happen.</p>	<p>The MAPIR application includes a set of default reports that can be executed electronically within the administration function for oversight, administration, and integrity. Transaction data is also reported on. In addition, message transactions occur automatically with the National Registration and Attestation System at CMS. These features and others are similar in terms of what is needed for the HIX.</p>
<p>7) Interoperability Condition</p> <ul style="list-style-type: none"> <li>• Seamless coordination and integration with the Insurance Exchange and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations;</li> <li>• Medicaid agency works with Exchanges to share business services and technology investments for seamless and efficient customer experiences;</li> <li>• Appropriate standardized messaging and communication protocols;</li> <li>• Data-sharing architecture to address</li> </ul>	<p>Vermont is pursuing many of the points in the Interoperability Condition set. The Eligibility system, based on Vermont's SOA core components, will be a major system component in the State's architecture for interoperability. It will interface with both the insurance exchange and the Medicaid systems, and will have the ready capability to interface with the additional types of agencies and programs identified in the Interoperability Condition. In Vermont, the Department of Vermont Health Access is the organizing force for the State's Medicaid operation, for the Insurance Exchange, and for the Health Reform Division - focused on Interoperability across the full spectrum of Health Care landscape in Vermont.</p>	<p>See item 6 above for a brief discussion of the MAPIR system's use of standardized messaging and communication protocols. To a limited extent, the data contained in these exchanged messages also reflect on the data architecture, sharing, ownership and security aspects of the Interoperability Condition.</p>

- data semantics, data harmonization strategies, shared-data ownership, security and privacy implications of shared data, and the quality of shared data;
- Open interfaces are established with federal data services hub, including the real-time requests to hubs following applications for eligibility;
- Describe how shared services will support both the Exchange and Medicaid;
- Interact with other entities to support interoperability with health information exchanges, public health agencies, and others to promote customer service and clinical management and health services;
- Engage community service organizations to determine how eligibility systems will be used to assist applicants for health care coverage with electronic form submissions.

Having these programs in a common organizational entity is a huge advantage in creating the potential for interoperability to the fullest extent possible. There are several examples of promoting both standardized messaging and communication protocols, AND engaging community service organizations and other agencies in the general push to interoperability. The Blueprint for Health has at its core the utilization of EHR technology and the accumulation of demographic and clinical data in a data repository. The Blueprint program incorporates, as a first initiator, data-sharing architecture, shared data ownership, and security and privacy as well. The State has also awarded a grant to an organization of designated agencies who provide substance abuse and mental health care services for the State. This grant will be used to survey and assess their EHR systems and identify gaps that exist to those system capabilities to exchange data with the HIE. The grant will also identify the meaningful data, in the form of a measure set, that would have value for exchange.

## 11 Prospective Cost Distribution

Vermont has been working closely with CMS on the Cost Allocation and Distribution plan as there are several funding mechanisms and as was mentioned throughout this document, the solutions often run across programs, across departments and across funding streams. Some of the funding streams involve are identified below. Be advised that some have time constraints but the State's plan is to leverage the various funding streams to maximize the State's opportunities to fund the appropriate and necessary work to meet its health reform goals.

- Section 11276.2 provides that 90% Federal Financing Participation (FFP) is available for costs directly attributable to the Medicaid program for the design, development, installation and enhancement of MMIS and information retrieval systems.
- Medicaid IT Supplement (MITS-11-01-v1.0) addresses the changes in 42 CFR Part 433 that grants enhanced funding for Eligibility and Enrollment (E&E) systems at 90%FFP for expenditures for the design, development and installation or enhancement of Medicaid eligibility determination systems.
- Medicaid IT Supplement (MITS-11-02-v1.0) addresses enhanced federal funding for Medicaid Information Technology (IT) system(s) projects related to eligibility and enrollment functions and in particular, Early Innovator or Establishment grant efforts associated with Insurance Exchange activities. The FFP associated with this work is 100% for design, development and installation efforts.
- The HITECH Act allows for 100% FFP for EHRIP payments. The State administers these payments so while there's no State expense for the 'payments', the State has the responsibility to administer the program and thus needs to account for that work.

As mentioned earlier, we have categorized the work into four distinct areas/funding buckets:

1. Core Components
2. Health Insurance Exchange (HIX) / Health Eligibility and Enrollment (E&E)
3. Medicaid Enterprise Service (MES)
4. State Medicaid HIT Plan (SMHP)

Within each of the areas, Vermont added in some 'standard expenses' to be calculated in, such as:

- Change Management (30% of DDI)
- Quality Assurance/Code Review (10% of DDI)
- Independent Verification and Validation (IV&V) (5% of DDI)
- DII Costs (3% of DDI)

The State organized its cost allocation in terms of answering the following questions when looking at specific work activities in relation to each category above:

- 1) Does this work address a need in this area (1->4 above) and make note of that?

- 2) After going through each category, what's the appropriate method for calculating how to distribute (what percentage) each category's involvement? This could be based on # of members, # of servers, # of employees, cost, etc.

Looking at the budget tables in Section 6, for question 1 above, for example, eMPI (MDM) effects Infrastructure/Core Components (CMS-MMIS), Eligibility and Enrollment (CMS-E&E), and Insurance Exchange (CCIIO) whereas Provider Directory effects Infrastructure/Core Components (CMS-MMIS), Eligibility and Enrollment (CMS-E&E), Insurance Exchange (CCIIO) AND SMHP (CMS-HIT). And for question 2 above, it was determined that the most effective/cleanest way to calculate percent was to look at for eMPI, the number of enrollees (or anticipated enrollee in the case of the HIX).

Staff costs will be distributed according to time personnel devoted to these projects. Vermont has an approved time accounting system in place to credit work to the appropriate accounts, and will be reported under the federally approved Cost Allocation Plan (CAP).

The accompanying spreadsheet, Vermont\_Health\_Enterprise\_Budget\_v4, contains seven tabs that organize and document the anticipated costs, cost allocation, resources, and other data used to calculate the Cost Allocation associated with the Vermont Health Enterprise initiatives. The tabs are further explained below.

- DDI Spread
  - Provides the holistic view of the Health Enterprise Cost allocation and budget totals including:
    - Display of specific work activities (columns A, B and C) with color coordination
      - Core Components in violet
      - Health Insurance Exchange (HIX) in light blue
      - Health Eligibility and Enrollment (E&E) in dark blue
      - Medicaid Enterprise Solution (MES) in green
      - State Medicaid Health Information Technology Plan (SMHP) in orange
      - Other Medicaid Management Information Systems (MMIS) projects in yellow
        - These are documented here to show other related efforts though the costs for these are not included in this APD.
    - Display of standard expenses that make up each specific work activity (column C)
      - Contracts that are/will come out of each effort
      - Design, Develop and Implementation (DDI) costs
      - Change Management (30 % of DDI)
      - Quality Assurance (including code review) (10% of DDI)
      - Independent Verification and Validation (IV&V) (5% of DDI)
      - DDI Project Management (3% of DDI)
        - Providing enterprise architecture services and project management oversight to mitigate risks associated with projects involving

technology. Budget is set at 3% of project costs yet billing will be for actual cost of the services.

- Note: in the Core Components there is also the cost estimate for the cloud development as noted by DII of how the health care development will be performed
  
- Display of Funding buckets (rows 2 through 11) that show:
  - Sources of funds such as: CMS-MMIS, CMS-E&E, CMS-HIT, CCIIO, CMS-MMIS (for 'related but not part of this APD' effort), and Other work (future initiatives)
  - Name and type of the former APDs and focus areas that are now included in this APD
  - Program codes that show State-time tracking codes
  - Funding totals (Federal/State/Total)
  - Dates and status of these previous APDs
  - NOTE: the colors for these buckets are used to identify each bucket and do NOT correspond with the colors of the work activities. These are meant to only show each 'bucket'.
  
- Staffing
  - Provides the holistic view of the resource/staffing allocation and budget totals including:
    - Display of the core roles (column D) that are needed to be filled along with the anticipated # of people needed over the course of the next 3 years (knowing we'll continue to revise/update this APD as work continues)
      - Who/where the role will be provided from (column A)
      - Annual cost and 3 year total for roles (columns B and C)
  
- Timeline
  - Provides the holistic view of the timeline including:
    - Display of specific work activities with start, build and anticipated completion dates
  
- Lmtd\_positions
  - Provides a reference table (mostly for VT staff) to track specific positions that were a result of previous APDs and thus are/will be part of this APD
  
- 0911Medicaid
  - Contains the Global Commitment (GC) and claims figures from which certain allocation costs were determined

- Paid claims counts
- Recent enrollment figures
- Insured
  - Contains the Insured figures from which certain allocation costs were determined
    - Population figures
    - Enrollment figures
    - Covered (Insurance) numbers for various coverage groups
- APD Tables
  - Contains the tables used for inclusion in this APD – see below:

The following table provides a high level view of the various work activities/focus areas and expected costs with breaking out what was funded out of previous APDs and what is included in this IAPD:

	Current APDs	Total Est. Cost	New IAPD Need
<b>CORE COMPONENTS &amp; SHARED SERVICES</b>	\$9,609,033	\$105,894,365	\$99,515,173
Health Insurance Exchange	\$19,090,369	\$31,403,450	\$14,993,450
Health Care Eligibility and Enrollment	\$34,664,034	\$57,060,437	\$43,699,937
<b>MEDICAID ENTERPRISE SOLUTION</b>	\$7,705,295	\$159,351,500	\$160,872,500
<b>SMHP-RELATED PROJECTS AND FUNDING</b>	\$4,290,597	\$10,924,835	\$10,321,611
Other MMIS Projects	\$1,171,549	\$0	\$0
<b>Total All Projects</b>	<b>\$76,530,877</b>	<b>\$364,634,587</b>	<b>\$329,402,671*</b>

The following table provides the funding totals as to what buckets/sources of funds the State is anticipating:

	CMS	SMHP	OCCIO	Total
Total by Funding Bucket	\$202,173,982	\$8,390,037	\$108,738,652	\$319,302,671*
Federal Match (FPL)	90%	90%	100%	93%
Federal Share	\$181,956,584	\$7,551,034	\$108,738,652	\$298,246,269
State Share	\$20,217,398	\$839,004	\$0	\$21,056,402

\* The \$10.1M difference is a result of HIX Funding of an estimated amount of Level 2 Establishment Grant IT Funding.

## 12 Cost Distribution Summary

Section 11276.2 provides that 90% FFP is available for the costs directly attributable to the Medicaid program for the design, development, installation and enhancement of MMIS and information retrieval systems.

Section 6 (Personnel Resource Statement) and Section 9 (Proposed Budget) list provide further detailed information regarding FFP.

## 13 Statement of Security and Interface Requirements

The security and interface requirements pertaining to this IAPD are the same as they were for previous Vermont APDs that have been approved already by CMS. Vermont will plan to build interfaces and security protocols for AHS systems following accepted National and Industry standards to ensure that Health Enterprise interactions exhibit data being stored and transmitted in a secure, timely and responsive manner.

## 14 Backup and Fallback Contingency Procedures

There is planning in place to develop/investigate potential contingency plans, though no separate backup and fallback procedures have been developed as of this time. This work is mandated and if it is not completed it will negatively impact providers and therefore the State is committing the resources to achieve this goal. A causal effect of combining our health care reform projects into one over-arching I-APD submission is that the consequences of non-approval become much more severe. These projects represent years of work from a plethora of State employees, and disapproval of this I-APD would bring health care advancements in the State of Vermont to a screeching halt.

## 15 Assurances the State Has Met the Requirements

The State of Vermont certifies that it has met the requirements for (1) Procurement Standards (Competitive/sole Source) 45 CFR Part 95.613, 45 CFR Part 92, SMM Section 11267 (2) Access to Records 45 CFR Part 95.615, SMM Section 11267 (3) Software Ownership, Federal Licenses and Information Safeguarding 42 CFR Part 433.112(b)(5) – (9), and (4) Progress Reports SMM Section 11267. For additional information, refer to Section 10.

The State of Vermont certifies that it has its share of the funds required to complete the activities described in this IAPD available in our budget. The State requests approval to proceed with federal funding at the above levels.

Vermont has completed the required Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) although the State is planning on updating this document upon the release of MITA 3.0.